EXHIBIT “A”

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

THE CHALLENGE PRINTING COMPANY EMPLOYEE BENEFIT PLAN

(MEDICAL, PRESCRIPTION DRUG, VISION AND DENTAL)

EFFECTIVE AS OF:
December 1, 2005

Updated as of: April 1, 2006
(Amendments Incorporated)
(Includes Amendments 2-06, 3-06, 1-07 - 3-07)

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SUMMARY OF MATERIAL MODIFICATION
AND AMENDMENT 3-07
to the
The Challenge Printing Co., Inc. Employee Benefit Plan
Effective December 1, 2005

This Summary of Material Modification and Amendment describes changes to The Challenge Printing Co., Inc. Employee Benefit Plan. **These changes are effective as of June 1, 2007** and will remain in effect until amended in writing by the Plan Sponsor.

You should read this document carefully and staple this Summary of Material Modification to your Plan Document and Summary Plan Description. Please contact your Plan Administrator identified in your Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

The Challenge Printing Co., Inc. (the "Plan Sponsor") wishes to amend The Challenge Printing Co., Inc. Employee Benefit Plan (the "Plan") as follows:

1. **Add the Schedule of Dental Benefits Platinum Plan Option to the Plan (Attachment D).**

2. **Add the Schedule of Vision Care Benefits Platinum Plan Option to the Plan (Attachment E).**

3. **Rename the current Schedule of Dental Benefits to the following:**

SCHEDULE OF DENTAL BENEFITS
GOLD AND SILVER PLAN OPTIONS

4. **Rename the current Schedule of Vision Care Benefits All Option to the following:**

SCHEDULE OF VISION CARE BENEFITS
GOLD AND SILVER PLAN OPTIONS

Attachment D

SCHEDULE OF DENTAL BENEFITS
PLATINUM PLAN OPTION

BENEFIT DESCRIPTION	BENEFIT
Maximum Benefit Amount	
For all classes other than Class D-Orthodontia: Per Covered Person per calendar year	$3,000
For Class D-Orthodontia: (available for covered Dependent children under age 19) Lifetime maximum per Covered Person	$1,500
Dental Percentage Payable	
Class A Services-Preventive	100% of U&C
Class B Services-Basic	100% of U&C
Class C Services-Major	100% of U&C
Class D Services-Orthodontia	50% of U&C

A written proposed course of treatment for any procedure estimated to be over $300 should be submitted by the Dentist for review prior to the actual performance of services. Evaluation of the course of treatment is subject to the alternate procedure provision of the Plan and does not guarantee payment of benefits when the actual services are performed.

Details regarding Dental Benefits are in the Dental Benefits section.

Attachment E

SCHEDULE OF VISION CARE BENEFITS
PLATINUM PLAN OPTION

BENEFIT DESCRIPTION	BENEFIT
Vision Benefits are limited to the following:	
Eye exam and Vision hardware, per Covered Person, per calendar year (Includes: Frames, Frame – type lenses and contact lenses)	$500

Details regarding Vision Benefits are in the Vision Benefits section.

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SUMMARY OF MATERIAL MODIFICATION
AND AMENDMENT 2-07
to the
The Challenge Printing Co., Inc. Employee Benefit Plan
Effective December 1, 2005

This Summary of Material Modification and Amendment describes changes to The Challenge Printing Co., Inc. Employee Benefit Plan. **These changes are effective as of March 1, 2007** and will remain in effect until amended in writing by the Plan Sponsor.

You should read this document carefully and staple this Summary of Material Modification to your Plan Document and Summary Plan Description. Please contact your Plan Administrator identified in your Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

The Challenge Printing Co., Inc. (the "Plan Sponsor") wishes to amend The Challenge Printing Co., Inc. Employee Benefit Plan (the "Plan") as follows:

For the Platinum Option, the Outpatient Mental Disorders calendar year maximum has increased from 30 visits to 104 visits. As such, delete the Outpatient Mental Disorders benefit under the Mental Disorders and Substance Abuse subsection of the Schedule of Medical Benefits Platinum Option (as amended by way of Amendment 1-06) and replace with the following:

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Mental Disorders and Substance Abuse			
Outpatient Mental Disorders	100% 104 visit calendar year maximum	100% U&C 104 visit calendar year maximum	Includes certain Family Counseling and Marital Counseling.

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SUMMARY OF MATERIAL MODIFICATION
AND AMENDMENT 1-07
to the
The Challenge Printing Co., Inc. Employee Benefit Plan
Effective December 1, 2005

This Summary of Material Modification and Amendment describes changes to The Challenge Printing Co., Inc. Employee Benefit Plan. **These changes are effective as of March 1, 2007** and will remain in effect until amended in writing by the Plan Sponsor.

You should read this document carefully and staple this Summary of Material Modification to your Plan Document and Summary Plan Description. Please contact your Plan Administrator identified in your Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

The Challenge Printing Co., Inc. (the "Plan Sponsor") wishes to amend The Challenge Printing Co., Inc. Employee Benefit Plan (the "Plan") as follows:

1. **The amount of hours that an Employee must work per week to be considered a Full-Time Active Employee has increased from 34 hours per week to 38 hours per week. As such, delete bullet (1) under the Eligible Classes of Employees subsection of the Eligibility and Commencement of Coverage Provisions and replace with the following:**

   (1) a full-time Employee regularly scheduled to work at least 38 hours per week for the Employer (as determined by the Employer) and is on the regular payroll of the Employer.

2. **Add the following Interactive Health Solutions Program section to the Plan:**

INTERACTIVE HEALTH SOLUTIONS PROGRAM

About Interactive Health Solutions

Through Interactive Health Solutions, the Plan offers a program that provides An Eligible Participant with the convenience of on-site health screenings. The program is based on three core strategies: Discovery, Education and Control and is intended to help An Eligible Participant identify health issues that they are unaware of.

The benefits offered through Interactive Health Solutions are always paid at 100% and are not subject to a co-pay or deductible.

Eligible Participants Defined

An Individual is considered to be an eligible individual if they are an Employee.

How the Program works

1. Discovery

    a. Interactive Health Solutions will come to the Employer's corporate location (or other designated location providing certain criteria are met) and perform a health profile test, which will consist of the following:

    - Blood chemistry profile – 24 individual tests to help detect diabetes, kidney disease, liver disease, and bone and muscle disease. Also analyzes total cholesterol, LDL and HDL cholesterol and triglycerides.
    - Complete blood count – 9 individual tests to help detect anemia, leukemia, bleeding abnormalities, infections, and certain cancers.
    - Blood pressure analysis
    - Medical history – A review of the participant's personal and family medical history that is used to more accurately assess health risks, evaluate screening results, and provide information on targeting personalized health information to the person.
    - Coronary risk trend analysis – Health professionals will track and compare the cholesterol, HDL, LDL, triglycerides and glucose levels each year a participant is screened.

2. Education

    a. Within 48 hours of performing the profile test, the Employee can access their personal health report online.

    b. Online access to health information will also be provided so that an Employee may quickly understand their condition and how to lead a healthier lifestyle. An Employee may also receive online consultation as necessary.

    c. Periodically throughout the year, the Employee will receive emails containing the latest health and wellness information.

3. Control

    a. An Employee will have access to a masters-degreed personal health coach by telephone to health the Employee better manage their health. These health management and behavior medication courses are designed to assist An Eligible Participant in making lasting, healthy lifestyle changes. Courses include:

    - Smoke-free for life
    - Lifestyles for successful weight loss
    - Diabetes prevention and control
    - Managing cholesterol levels
    - Managing and preventing high blood pressure
    - Personalized fitness
    - Better nutrition
    - Preventing and managing back pain
    - Controlling your asthma
    - Achieving balance (stress management)

SUMMARY OF MATERIAL MODIFICATION
AND AMENDMENT 3-06
to the
The Challenge Printing Co., Inc. Employee Benefit Plan
Effective December 1, 2005

This Summary of Material Modification and Amendment describes changes to The Challenge Printing Co., Inc. Employee Benefit Plan. **These changes are effective as of October 1, 2006** and will remain in effect until amended in writing by the Plan Sponsor.

You should read this document carefully and staple this Summary of Material Modification to your Plan Document and Summary Plan Description. Please contact your Plan Administrator identified in your Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

The Challenge Printing Co., Inc. (the "Plan Sponsor") wishes to amend The Challenge Printing Co., Inc. Employee Benefit Plan (the "Plan") as follows:

Add Beech Street as a Participating Provider Organization for Employees and their eligible Dependents residing in the State of New Jersey. As such, delete the Participating Provider Organization subsection of the Schedule of Benefits section and replace with the following (by way of Amendment 1-06):

Employee State of Residence	Participating Provider Organization
NJ, NY, MA, OH, NV, PR and IL	PHCS
PA and NJ	Beech Street
NC	MedCost
PR	Multiplan

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SUMMARY OF MATERIAL MODIFICATION
AND AMENDMENT 2-06
to the
The Challenge Printing Co., Inc. Employee Benefit Plan
Effective December 1, 2005

This Summary of Material Modification and Amendment describes changes to The Challenge Printing Co., Inc. Employee Benefit Plan. These changes are effective as of March 1, 2006 and will remain in effect until amended in writing by the Plan Sponsor.

You should read this document carefully and staple this Summary of Material Modification to your Plan Document and Summary Plan Description. Please contact your Plan Administrator identified in your Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

The Challenge Printing Co., Inc. (the "Plan Sponsor") wishes to amend The Challenge Printing Co., Inc. Employee Benefit Plan (the "Plan") to reflect the requirements of certain federal Regulations applicable to the Plan. Therefore, the Plan is amended as follows:

1. **Delete the third sentence of bullet two under the Eligibility Requirements for Employee Coverage subsection and replace with the following:**

   For the purpose of this provision, an Employee shall not be treated as absent from work if the absence is because of a health condition.

2. **Delete the Dependents Residing Outside the United States of America subsection and replace with the following:**

   Dependents Residing Outside the United States of America. If an otherwise eligible Dependent is not enrolled in the Plan because he or she does not reside in the United States, the Employee is permitted to enroll the Dependent in the Plan. Coverage will be effective on the date of relocation, provided the request for enrollment in the Plan is received within 30 days after the Dependent relocates to the United States of America. This rule does not apply to coverage provided through a Section 125 Plan. For coverage provided through a Section 125 Plan, the Employee will be able to enroll the Dependent under these circumstances only if a Special Enrollment Right applies or a Change in Status election is permitted under the terms of the Section 125 plan.

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AMENDMENT NUMBER ONE AND SUMMARY OF MATERIALS MODIFICATION TO THE CHALLENGE PRINTING CO., INC. EMPLOYEE BENEFIT PLAN

To: Participants in The Challenge Printing Co., Inc.
From: Human Resources
Re: Changing of Third Party Administrator and Claims Processor
Effective December 1, 2008.

This Agreement hereby Amends The Challenge Printing Co., Inc. Employee Benefit Plan, Effective December 1, 2008.

A. Plan Amendments

On page 3 of Employee Benefit Plan remove the following language:

Call Performax Care Manager for precertification: Performax Care Manager 1-(800)-337-0506. Detailed information regarding precertification requirements and penalties for failure to comply can be found in the Performax Care Manager Program section.

On page 3 of Employee Benefit Plan add the following language:

Cost Management Services- HealthCare Strategies - Phone Number (888) 599-1515 prompt # 2. Detailed information regarding precertification requirements and penalties for failure to comply can be found on pages 43-44 of The Challenge Printing Company Employee Benefit Plan Document.

On Pages 43 through 49 remove all Performax Care Manager References.

On Pages 43 through 49 add HealthCare Strategies

On Page 58 under Prescription Drug Benefits remove the following language:

Performax Script World is the administrator of the Prescription Drug Program.

On Page 58 under Prescription Drug Benefits add the following language:

Express Scripts, Inc. is the administrator of the Prescription Drug Program.

On Page 58 under Direct Reimbursement remove the following language:

Performax Prescription Manager at the following address:
Performax Scrip World
C/o Express Scripts, Inc.
P.O. Box 66773
St. Louis, MO 63166-6773
Attn: Claims Department

On Page 58 under Direct Reimbursement add the following language:

Express Scripts, Inc.
P. O. Box 667583
St. Louis, MO 63166-6773
Attn: Claims Department

On Page 66 Under Dental remove the following language:

The Dentist should send the form to the Claims Processor at this address:

Performax Claims Processor
P. O. Box 1065
Amherst, New York 14226
1-(877)-777-6076

On Page 66 Under Dental add the following language:

The Dentist should send the form to the Claims Processor at this address:

Insurance Administrator of America, Inc.
P. O. Box 5082
Mt. Laurel, NJ 08054
(888) 599-1515

On Page 68 Under Filing A Claim remove the following language:

(1) Obtain a claim form from the Human Resource Department, The Plan Administrator or on-line at MyPERFORMAX.com

(5) Mail the completed claim form and attached documentation to the Claims Processing Office or at the address listed below:

PERFORMAX Claims Processor
P. O. Box 1065
Amherst, New York 14226

Questions regarding the claim can be addressed by calling the following toll-free number: 1-(877)-777-6076.

On Page 68 Under Filing A Claim add the following language:

(1) Obtain a claim form from the Human Resource Department, The Plan Administrator or on-line at www.iaatpa.com

(5) Mail the completed claim form and attached documentation to the Claims Processing Office or at the address listed below:

Insurance Administrator of America, Inc.
P. O. Box 5082
Mt. Laurel, NJ 08054

Questions regarding the claim can be addressed by calling the following toll-free number: 1-(888)-599-1515.

On Page 81 Under Cobra Continuations remove the following language:

This notice must be provided, along with any required documentation to:

Plan Administrator
COBRA Qualifying Event
The Challenge Printing Co., Inc.
2 Bridewell Place
Clifton, New Jersey 07014
(973)-471-4700

On Page 81 Under Cobra Continuations add the following language:

This notice must be provided, along with any required documentation to:

Insurance Administrator of America, Inc.
P. O. Box 5082
Mt. Laurel, NJ 08054
1-(888)-599-1515

On Page 91 Under General Plan Information Claims Processor delete the following language:

Claims Processor
PERFORMAX Claims Processor
P.O. Box 1065
Amherst, New York 14226
1-(877)-777-6076

On Page 91 Under General Plan Information Claims Processor add the following language:

Claims Processor
Insurance Administrator of America, Inc.
P. O. Box 5082
Mt. Laurel, NJ 08054
1-(888)-599-1515

IN WITNESS WHEREOF, this agreement has been executed the 2nd Day of February, 2008 2009

BY: _____
Employer

Witness

A. Summary of Material Modifications

Effective December 1, 2008, The Challenge Printing Co., Inc. Employee Benefit Plan has amended the Plan with reference to Third Party Billing Administrator and Care Manager.

Please attach this document to your SPD for future reference. If you have any questions, please contact the Plan Sponsor.

ERISA Information

Plan Sponsor:	The Challenge Printing Co., Inc. 2 Bridewell Place Clifton, NJ 07014 973-471-4700 The Challenge Printing Co. of the Carolinas, Inc. 5905 Clyde Rhyne Dr. Sanford, NC 27330 919-777-2820
Plan Sponsor's EIN:	22-1852608
Plan Name:	The Challenge Printing Co., Inc. Employee Benefit Plan
Claims Processor:	Insurance Administrator of America, Inc. P. O. Box 5082 Mt. Laurel, NJ 08054
Plan #:	501
Plan Year:	~~December 1, 2005~~ December 1, 2002

TW 2/2/09

AMENDMENT NUMBER TWO AND SUMMARY OF MATERIAL MODIFICATIONS TO CHALLENGE PRINTING CO., INC. GROUP HEALTH BENEFIT PLAN

To: Participants in the Challenge Printing Co., Inc. Group Health Benefit Plan
From: Human Resources
Re: Children's Health Insurance Program Reauthorization Act of 2009
Date: April 1, 2009

BY THIS AGREEMENT, CHALLENGE PRINTING CO., INC. GROUP HEALTH BENEFIT PLAN is hereby amended as follows effective April 1, 2009.

WHEREAS, effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (the "Act") permits a Plan to allow special enrollment for eligible but not enrolled employees or dependent child who either (1) lose coverage under a Medicaid or a State Children's Health Insurance Plan (SCHIP) under titles XIX and XXI of the Social Security Act, respectively, or (2) become eligible for group health plan premium assistance under Medicaid or SCHIP("Special Enrollment Right"); and

WHEREAS, effective April 1, 2009 the Employer desires to amend the Plan to allow for a Special Enrollment Right that is consistent with the requirements set forth in the Act; and

IN WITNESS WHEREOF, this agreement has been executed the 1st Day of April ,2009.

By: _____
Employer

_____
Witness

SUMMARY OF MATERIAL MODIFICATIONS TO THE CHALLENGE PRINTING CO., INC. GROUP HEALTH BENEFIT PLAN

This document summarizes important changes to your Group Health Benefit Plan. You should keep a copy of this SMM with your Plan Document for future reference.

Effective April 1, 2009, eligible employees and participants will have a "Special Enrollment Right" under the Group Health Benefit Plan that allows certain eligible but un-enrolled employees and Participants to enroll in a Benefit Plan Option that is group health plan if the dependent child or employee: (1) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act; (2) loses coverage under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or (3) becomes eligible for group health plan premium assistance under Medicaid or SCHIP. The eligible employee or participant must request an election change to enroll in group health plan coverage within 60 days from the date (1) the coverage terminates under the Medicaid or SCHIP plan or (2) the employee or dependent child is determined eligible for state premium assistance.

If you believe you are eligible for a Special Enrollment, you must contact the Administrator to request an election form as soon as possible. A request for enrollment must be made in writing on the form provided by your employer. A request for a Special Enrollment right must be made within 60 days of an event described above that occurs on or after April 1, 2009.

AMENDMENT NUMBER THREE AND SUMMARY OF MATERIAL MODIFICATIONS TO CHALLENGE PRINTING CO., INC. GROUP HEALTH BENEFIT PLAN

To: Participants in the Challenge Printing Co., Inc., Group Health Benefit Plan
From: Human Resources
Re: The American Recovery and Reinvestment Act of 2009 COBRA Provisions
Date: February 17, 2009

BY THIS AGREEMENT, CHALLENGE PRINTING CO., INC. GROUP HEALTH BENEFIT PLAN is hereby amended as follows effective February 17, 2009.

WHEREAS, effective February 17, 2009, the American Recovery and Reinvestment Act of 2009 (the "Act") requires the plan to allow for the provisions outlined below.

Eligible qualified beneficiaries (called "assistance eligible individuals" in the Act) can satisfy the payment of their COBRA continuation premium by paying 35% of the COBRA premium due. The Act requires employers to subsidize the remaining 65% of the premium for a period generally not longer than 9 months. Employers paying the 65% will be able to offset such amounts by receiving a payroll tax credit against federal income and FICA taxes.

An "assistance eligible individual" is a person who: 1) is involuntarily terminated from employment and is eligible for COBRA any time between September 1, 2008 and December 31 2009.

The Act also allows for a COBRA election extension period, requiring employers to offer COBRA continuation coverage to those individuals who failed to elect COBRA when first eligible but who would otherwise be eligible if they did elect COBRA. The election period begins on the date the law was enacted (February 17, 2009) and ends 60 days after the individual receives the special election extension notice. For an individual who elects COBRA during this special election extension period, the period of time between the individual's original qualifying event date and the effective date of COBRA coverage shall not be counted against the individual when determining a 63-day break-in-coverage for pre-existing condition purposes.

IN WITNESS WHEREOF, this agreement has been executed the 16th Day of April, 2009.

By: _____
Employer

_____
Witness

AMENDMENT NUMBER FOUR AND SUMMARY OF MATERIAL MODIFICATIONS TO CHALLENGE PRINTING CO., INC.
GROUP HEALTH BENEFIT PLAN

To: Participants In The Challenge Printing Co., Inc. Group Health Benefit Plan
From: Human Resources
Re: Benefit Changes – Adding Injectable Medication $50,000 limit to Medical Schedule Of Benefits Under Home Health Care Benefit – All Plans.
Addition of H S A Plan Option
Date: Effective December 1, 2009

BY THIS AGREEMENT, THE CHALLENGE PRINTING CO., INC. GROUP HEALTH BENEFIT PLAN is hereby amended as follows effective December 1, 2009.

A. Plan Amendments

Injectable medications will no longer be covered under the prescription plan and will now be covered under the medical schedule of benefits with a $50,000 calendar year maximum payable under the Home Health Care Benefit.

Addition of a H S A Plan Option.

See attached Schedules of Benefits for all plans.

IN WITNESS WHEREOF, this agreement has been executed the 1st Day of December, 2009.

By: _____
Employer

_____
Witness

B. Summary of Material Modifications

Effective December 1, 2009, The Challenge Printing Co., Inc. Group Health Benefit Plan has amended the Plan with reference to Injectable Medication $50,000 limit payable under the Home Health Care Benefit. Addition of an H S A Plan.

Please attach this document to your SPD for future reference. If you have any questions, please contact the Plan Sponsor.

ERISA Information

Plan Sponsor:	The Challenge Printing Co., Inc. 2 Bridewell Place Clifton, NJ 07014 973-471-4700 The Challenge Printing Co. of the Carolinas, Inc. 5905 Clyde Rhyne Dr. Sanford, NC 27330 919-777-2820
Plan Sponsor's EIN:	22-1852608
Plan Name:	The Challenge Printing Co., Inc. Group Health Benefit Plan
Claims Processor:	Insurance Administrator of America, Inc. P. O. Box 5082 Mt. Laurel, NJ 08054
Plan #:	501
Plan Year:	2009

AMENDMENT NUMBER FIVE AND SUMMARY OF MATERIAL MODIFICATIONS TO CHALLENGE PRINTING CO., INC.
GROUP HEALTH BENEFIT PLAN

To: Participants in The Challenge Printing Co., Inc. Group Health Benefit Plan
From: Human Resources
Re: Personal Leave, Disability Leave and Layoff provisions.
Date: Effective December 1, 2009

BY THIS AGREEMENT, THE CHALLENGE PRINTING CO., INC. GROUP HEALTH BENEFIT PLAN is hereby amended as follows effective December 1, 2009.

A. Plan Amendments

Under Continuation During Periods of Disability, Personal Leave of Absence or Layoff on page 40 of the Plan Document the following language is deleted:

The end of the third calendar month that follows the month in which the covered Employee last worked as an Active Employ The end of the third calendar month that follows the month in which the covered Employee last worked as an Active Employee.

Under Continuation During Periods of Disability, Personal Leave of Absence or Layoff on page 40 of the Plan Document the following language is added:

The end of the third calendar month that follows the qualifying event. If multiple events apply, the end of the third calendar month of the last event.

IN WITNESS WHEREOF, this agreement has been executed the 1st Day of December, 2009.

By: _____
Employer

_____
Witness

B. Summary of Material Modifications

Effective December 1, 2009, The Challenge Printing Co., Inc. Group Health Plan has amended the Plan with reference to Personal Leave, Disability Leave and Layoff provisions

Please attach this document to your SPD for future reference. If you have any questions, please contact the Plan Sponsor.

ERISA Information

Plan Sponsor:	The Challenge Printing Co., Inc. 2 Bridewell Place Clifton, NJ 07014 973-471-4700 The Challenge Printing Co. of the Carolinas, Inc. 5905 Clyde Rhyne Dr. Sanford, NC 27330 919-777-2820
Plan Sponsor's EIN:	22-1852608
Plan Name:	The Challenge Printing Co., Inc. Group Health Benefit Plan
Claims Processor:	Insurance Administrator of America, Inc. P. O. Box 5082 Mt. Laurel, NJ 08054
Plan #:	501
Plan Year:	2009

AMENDMENT NUMBER SIX TO THE CHALLENGE PRINTING CO., INC.
GROUP HEALTH BENEFIT PLAN

To: Participants in The Challenge Printing Co., Inc. Group Health Benefit Plan
From: Human Resources
Re: Benefit Changes – Michelle's Law
Date: Effective December 1, 2009

BY THIS AGREEMENT, THE CHALLENGE PRINTING CO., INC. GROUP HEALTH BENEFIT PLAN is hereby amended as follows effective December 1, 2009.

Eligible Class of Dependents. The Plan's definition of "Eligible Class of Dependents" is amended by the addition of the following paragraph:

The requirement that a Dependent child have full-time student status in order to extend coverage past a stated age will generally not apply if the child's failure to maintain full-time status is due to a medically necessary leave of absence or other change in enrollment (such as reduction of hours). If the child's treating physician certifies in writing that the child is suffering from a serious illness or injury, and that the leave of absence or other change in enrollment is medically necessary, coverage may continue for up to a year after the date the medically necessary leave of absence or other change in enrollment begins. To be eligible for the extension, the child must be enrolled in the Plan as a full-time student immediately before the first day of the medically necessary leave of absence. This extension of coverage continues to apply if the manner of providing coverage under the Plan changes (such as from self-funded to fully insured) if the changed coverage continues to provide coverage for dependent children. However, this extension does not extend coverage beyond the date that a child fails to meet the dependent eligibility requirements other than the requirement to be a full-time student.

Except for a student who is on a medically necessary leave of absence, full-time student coverage continues between semester/quarters only if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

IN WITNESS WHEREOF, this agreement has been executed the 1st Day of December, 2009.

By: _____
Employer

_____
Witness

A. Summary of Material Modifications

Effective December 1, 2009, The Challenge Printing Co., Inc. Group Health Plan has amended the Plan with reference to Michelle's Law.

Please attach this document to your SPD for future reference. If you have any questions, please contact the Plan Sponsor.

ERISA Information

Plan Sponsor:	The Challenge Printing Co., Inc. 2 Bridewell Place Clifton, NJ 07014 973-471-4700 The Challenge Printing Co. of the Carolinas, Inc. 5905 Clyde Rhyne Dr. Sanford, NC 27330 919-777-2820
Plan Sponsor's EIN:	22-1852608
Plan Name:	The Challenge Printing Co., Inc. Group Health Benefit Plan
Claims Processor:	Insurance Administrator of America, Inc. P. O. Box 5082 Mt. Laurel, NJ 08054
Plan #:	501
Plan Year:	2009

AMENDMENT NUMBER SEVEN AND SUMMARY OF MATERIAL MODIFICATIONS TO THE CHALLENGE PRINTING CO., INC. GROUP HEALTH BENEFIT PLAN

To: Participants in The Challenge Printing Co., Inc. Group Health Benefit Plan
From: Human Resources
Re: Mental Health Parity and Addiction Equity Act
Date: Effective December 1, 2009

BY THIS AGREEMENT, THE CHALLENGE PRINTING CO., INC. GROUP HEALTH BENEFIT PLAN is hereby amended as follows effective December 1, 2009.

Mental Health Parity and Addiction Equity Act. The "Treatment of Mental Disorders/Substance Abuse/Mental Disorders and Substance Abuse" under Covered Charges under the Medical Benefit Plan is amended by the addition of the following:

Regardless of any limitations on benefits for Mental Disorders/Substance Abuse Treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders/Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

IN WITNESS WHEREOF, this agreement has been executed the 1st Day of December, 2009.

By: _____
Employer

_____
Witness

A. Summary of Material Modifications

Effective December 1, 2009, The Challenge Printing Co., Inc. Employee Benefit Plan has amended the Plan with reference to Mental Health Parity and Addiction Equity Act.

Please attach this document to your SPD for future reference. If you have any questions, please contact the Plan Sponsor.

ERISA Information

Plan Sponsor:	The Challenge Printing Co., Inc. 2 Bridewell Place Clifton, NJ 07014 973-471-4700 The Challenge Printing Co. of the Carolinas, Inc. 5905 Clyde Rhyne Dr. Sanford, NC 27330 919-777-2820
Plan Sponsor's EIN:	22-1852608
Plan Name:	The Challenge Printing Co., Inc. Group Health Benefit Plan
Claims Processor:	Insurance Administrator of America, Inc. P. O. Box 5082 Mt. Laurel, NJ 08054
Plan #:	501
Plan Year:	2009

AMENDMENT NUMBER EIGHT AND SUMMARY OF MATERIAL MODIFICATIONS TO CHALLENGE PRINTING CO., INC.
GROUP HEALTH BENEFIT PLAN

To: Participants in the Challenge Printing Co., Inc. Group Health Benefit Plan
From: Human Resources
Re: Disability Leave
Date: January 1, 2010

BY THIS AGREEMENT, CHALLENGE PRINTING CO., INC. GROUP HEALTH BENEFIT PLAN is hereby amended as follows effective January 1, 2010.

A. Plan Amendments

Under Continuation During Periods of Disability, Personal Leave of Absence or Layoff on page 40 of the Plan Document under Section For Disability leave, the following language is deleted:

For Disability leave: The end of the **third** calendar month that follows the month on which the covered Employee last worked as an Active Employee. Disability leave is concurrent with the Family and Medical Leave (as defined by the Family Medical Leave Act of 1993 (FMLA).

The following language is added:

For Disability leave: The end of the **sixth** month that follows the month on which the covered Employee last worked as an Active Employee. Disability leave is concurrent with the Family and Medical Leave (as defined by the Family Medical Leave Act of 1993 (FMLA).

IN WITNESS WHEREOF, this agreement has been executed the 1st Day of January, 2010.

By: _____
Employer

Ashok S. Avadhani
Witness

A. Summary of Material Modifications

Effective January 1, 2010, The Challenge Printing Co., Inc. Employee Benefit Plan has amended the Plan with reference to Disability Leave.

Please attach this document to your SPD for future reference. If you have any questions, please contact the Plan Sponsor.

ERISA Information

Plan Sponsor:	The Challenge Printing Co., Inc. 2 Bridewell Place Clifton, NJ 07014 973-471-4700 The Challenge Printing Co. of the Carolinas, Inc. 5905 Clyde Rhyne Dr. Sanford, NC 27330 919-777-2820
Plan Sponsor's EIN:	22-1852608
Plan Name:	The Challenge Printing Co., Inc. Employee Benefit Plan
Claims Processor:	Insurance Administrator of America, Inc. P. O. Box 5082 Mt. Laurel, NJ 08054
Plan #:	501
Plan Year:	2009

AMENDMENT NUMBER NINE AND SUMMARY OF MATERIAL MODIFICATIONS TO CHALLENGE PRINTING CO., INC.
GROUP HEALTH BENEFIT PLAN

To: Participants in the Challenge Printing Co., Inc. Group Health Benefit Plan
From: Human Resources
Re: Adding Orthotic Coverage ($1,000 Calendar Year Maximum) to All Plans
Date: July 1, 2010

BY THIS AGREEMENT, CHALLENGE PRINTING CO., INC. GROUP HEALTH BENEFIT PLAN is hereby amended as follows effective July 1, 2010.

A. Plan Amendments

Orthotic Coverage with a calendar year maximum of $1,000 has been added to all schedules of benefits (which are attached)

The following Language for Exclusion (30) has been deleted:

Orthotics. Services in connection with orthotics

The following Language for Exclusion (30) has been added:

Orthotics. Services in connection with orthotics other than the $1,000 Calendar maximum listed on the schedule of benefits

IN WITNESS WHEREOF, this agreement has been executed the 1st Day of July, 2010.

By: _____
Employer
For The Challenge Printing Co, Inc.

Ashok S. Avadhani
Witness

A. Summary of Material Modifications

Effective July 1, 2010, The Challenge Printing Co., Inc. Employee Benefit Plan has amended the Plan with reference to Orthotic Coverage ($1,000 Calendar Year Maximum) to all plans.

Please attach this document to your SPD for future reference. If you have any questions, please contact the Plan Sponsor.

ERISA Information

Plan Sponsor:	The Challenge Printing Co., Inc. 2 Bridewell Place Clifton, NJ 07014 973-471-4700 The Challenge Printing Co. of the Carolinas, Inc. 5905 Clyde Rhyne Dr. Sanford, NC 27330 919-777-2820
Plan Sponsor's EIN:	22-1852608
Plan Name:	The Challenge Printing Co., Inc. Employee Benefit Plan
Claims Processor:	Insurance Administrator of America, Inc. P. O. Box 5082 Mt. Laurel, NJ 08054
Plan #:	501

AMENDMENT NUMBER TEN AND SUMMARY OF MATERIAL MODIFICATIONS TO CHALLENGE PRINTING CO., INC. GROUP HEALTH BENEFIT PLAN

To: Participants in the Challenge Printing Co., Inc. Group Health Benefit Plan
From: Human Resources
Re: Dependent Coverage to Age 26
Date: December 1, 2010

BY THIS AGREEMENT, CHALLENGE PRINTING CO., INC. GROUP HEALTH BENEFIT PLAN is hereby amended as follows effective December 1, 2010.

A. Plan Amendments

In the Plan Document page 34, Eligibility, Funding, Effective Date and Termination Provisions, Subsection Eligible Classes of Dependents.

The following language is removed:

A covered Employee's Spouse and unmarried children from birth to the limiting age of 19 years who is a tax dependent of the employee as defined in Code 152. The spouse and dependent children must have the same principal place of abode as the employee. However, a Dependent child will continue to be covered after age 19, provided the child is a full-time student at an accredited school, primarily dependent upon the covered Employee for support and maintenance, and is unmarried and under the limiting age of 25. When the child reaches either limiting age, coverage will end on his or her birthday. If the child does not maintain full-time status or graduates, coverage closes independent of limiting age. Full-time student coverage continues only between semester/quarters if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

The following language is added:

Effective December 1, 2010, a covered Employee's spouse and children from birth to the limiting age of 26 years will be covered. Dependent children eligibility is only continued past the limiting age of 19 if the dependent child does not have access to coverage through his or her own employer. When the Dependent child reaches the limiting age of 26, coverage will end on his or her 26th birthday.

IN WITNESS WHEREOF, this Agreement has been executed the 1st Day of December, 2010

By: _____
Employer

_____
Witness

Summary of Material Modifications

Effective December 1, 2010, The Challenge Printing Co., Inc. Employee Benefit Plan has amended the Plan with reference to Dependent Coverage up to Age 26.

Please attach this document to your SPD for future reference. If you have any questions, please contact the Plan Sponsor.

ERISA Information

Plan Sponsor:	The Challenge Printing Co., Inc. 2 Bridewell Place Clifton, NJ 07014 973-471-4700 The Challenge Printing Co. of the Carolinas, Inc. 5905 Clyde Rhyne Dr. Sanford, NC 27330 919-777-2820
Plan Sponsor's EIN:	22-1852608
Plan Name:	The Challenge Printing Co., Inc. Employee Benefit Plan
Claims Processor:	Insurance Administrator of America, Inc. P. O. Box 5082 Mt. Laurel, NJ 08054
Plan #:	501

AMENDMENT NUMBER ELEVEN AND SUMMARY OF MATERIAL MODIFICATIONS TO CHALLENGE PRINTING CO., INC. GROUP HEALTH BENEFIT PLAN

To: Participants in the Challenge Printing Co., Inc. Group Health Benefit Plan
From: Human Resources
Re: Removal of Limits – Lifetime Maximum and Routine
Date: December 1, 2010

BY THIS AGREEMENT, CHALLENGE PRINTING CO., INC. GROUP HEALTH BENEFIT PLAN is hereby amended as follows effective December 1, 2010.

The following Limits are removed:

1. Lifetime Limit of $2,000,000.
2. Routine Preventive Care limit of $500 has been removed.

The following language has been added:

1. Plan Year Limit of $2,000,000.
2. Under the Preventive Care Benefit: Coverage is subject to appropriate medical guidelines.

IN WITNESS WHEREOF, this agreement has been executed the 1st Day of December, 2010.

By: _____
Employer

_____
Witness

A. Summary of Material Modifications

Effective December 1, 2010, The Challenge Printing Co., Inc. Group Health Benefit Plan has amended the Plan with reference to Removal of Limits.

Please attach this document to your SPD for future reference. If you have any questions, please contact the Plan Sponsor.

ERISA Information

Plan Sponsor:	The Challenge Printing Co., Inc. 2 Bridewell Place Clifton, NJ 07014 973-471-4700 The Challenge Printing Co. of the Carolinas, Inc. 5905 Clyde Rhyne Dr. Sanford, NC 27330 919-777-2820
Plan Sponsor's EIN:	22-1852608
Plan Name:	The Challenge Printing Co., Inc. Employee Benefit Plan
Claims Processor:	Insurance Administrator of America, Inc. P. O. Box 5082 Mt. Laurel, NJ 08054

AMENDMENT NUMBER TWELVE AND SUMMARY OF MATERIAL MODIFICATIONS TO CHALLENGE PRINTING CO., INC. GROUP HEALTH BENEFIT PLAN

To: Participants in the Challenge Printing Co., Inc. Group Health Benefit Plan
From: Human Resources
Re: Removal of Pre-Existing Condition Limit for all members under the age of 19.
Date: December 1, 2010

BY THIS AGREEMENT, CHALLENGE PRINTING CO., INC. GROUP HEALTH BENEFIT PLAN is hereby amended as follows effective December 1, 2010.

The following language has been added to Page 33 under Eligibility and Commencement of Coverage Provision:

Pre-Existing Condition limitations do not apply to all members under the age of 19.

IN WITNESS WHEREOF, this agreement has been executed the 1st Day of December, 2010.

By: _____
Employer

_____
Witness

A. Summary of Material Modifications

Effective December 1, 2010, The Challenge Printing Co., Inc. Group Health Benefit Plan has amended the Plan with removal of Pre-Existing Condition Limits for All under the age of 19.

Please attach this document to your SPD for future reference. If you have any questions, please contact the Plan Sponsor.

ERISA Information

Plan Sponsor:	The Challenge Printing Co., Inc. 2 Bridewell Place Clifton, NJ 07014 973-471-4700 The Challenge Printing Co. of the Carolinas, Inc. 5905 Clyde Rhyne Dr. Sanford, NC 27330 919-777-2820
Plan Sponsor's EIN:	22-1852608
Plan Name:	The Challenge Printing Co., Inc. Employee Benefit Plan
Claims Processor:	Insurance Administrator of America, Inc. P. O. Box 5082 Mt. Laurel, NJ 08054

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INTRODUCTION

In the event of any conflict between this document and any other document or oral communication, this document will control.

This is the The Challenge Printing Company Employee Benefit Plan for Medical, Dental, Vision, and Prescription Drugs (the Plan), effective December 1, 2005.

The Plan Sponsor reserves the right to terminate or amend the Plan at any time and for any reason.

The Plan will pay benefits only for the eligible expenses incurred while this coverage is in force. Benefits are not payable for eligible expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

As used in this document, the word year refers to a calendar year. All annual benefit maximums and deductibles accumulate during the calendar year. The word Lifetime as used in this document refers to the period of time that a Plan Participant under the The Challenge Printing Company Employee Benefit Plan is covered.

If an Employee and eligible Dependents, if any, were covered under the The Challenge Printing Company Employee Benefit Plan, or any predecessor plan on the day immediately prior to December 1, 2005, any accumulated time toward the satisfaction of a waiting period or Pre-Existing Condition limitation under the The Challenge Printing Company Employee Benefit Plan will be counted toward the satisfaction of the waiting period or Pre-Existing Condition limitation outlined in this document.

If an Employee and eligible Dependents, if any, were covered under The Challenge Printing Company Employee Benefit Plan on the date immediately prior to December 1, 2005, any amounts accumulated between January 1, 2005 and the day prior to December 1, 2005 will apply toward the satisfaction of the annual deductible and/or out-of-pocket maximums outlined in the Schedule of Benefits.

Defined terms are capitalized and defined in the Defined Terms section. This document is divided into the following sections:

Schedule of Medical, Prescription Drug, Dental and Vision Benefits. Provides a description of the Plan's benefits.

Defined Terms. Defines Plan terms that have a specific meaning.

Eligibility and Commencement of Coverage Provisions. Explains eligibility and when coverage begins under the Plan.

Annual Enrollment Period. Explains when a Plan Participant can change plan and enrollment options.

Termination of Coverage and Extension of Coverage Provisions. Explains when a Plan Participants coverage would end and when a Plan Participant may extend coverage under the Plan.

PERFORMAX Care Manager Program Services. Explains the PERFORMAX Care Manager Program, which protects a Covered Person from significant health care expenses and helps to provide quality care.

This section should be read carefully since each Plan Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Medical Benefits. Provides a description of medical benefits provided under the Plan.

Plan Exclusions. Lists services, treatment and charges incurred that are not covered by the Plan.

Prescription Drug Benefit. Explains benefits provided under the independent drug program.

Vision Benefits. Provides a description of vision benefits provided under the Plan.

Dental Benefits. Provides a description of dental benefits provided under the Plan.

Filing a Claim. Explains how to submit a claim for consideration of benefits under the Plan.

Claims Procedure. Explains the procedures for filing a claim and the claim appeal process.

Coordination of Benefits. Explains the Plan benefit payment order when a Covered Person is covered under more than one plan providing benefits.

Other Important Plan Provisions. Explains other important Plan provisions.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of expenses when a Covered Person has a claim against another person because of injuries sustained.

COBRA Continuation Options. Explains continuation options available under the Plan.

Responsibilities for Plan Administration. Explains the responsibilities of the Plan Administrator.

Health Information Privacy. Summary of the Plan's HIPAA Privacy Policy.

General Plan Information. Provides general Plan information.

SCHEDULE OF BENEFITS

MEDICAL, PRESCRIPTION DRUG, VISION AND DENTAL BENEFITS

The following Schedule of Benefits describes the benefits of the Plan. Additional Plan provisions, which may affect benefit payment, can be found in the Benefit Description sections.

Required Precertification: The following services must be precertified or reimbursement from the Plan may be reduced or not available:

Hospitalizations
Inpatient Mental Disorder/Substance Abuse treatments
Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility stays
Home Health Care
Hospice Care
Outpatient Surgical Procedures, excluding surgery rendered in a Physician's office
Private Duty Nursing
IV Home Infusion Therapy
Inpatient Surgical Procedure
Infusion Chemotherapy, including services rendered in a Physician's office

The Plan does not require precertification for a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Call PERFORMAX Care Manager for precertification: PERFORMAX Care Manager
1-800-337-0506

Detailed information regarding precertification requirements and penalties for failure to comply can be found in the PERFORMAX Care Manager Program section.

Participating Provider Organization (PPO)

The Plan includes an arrangement with multiple Participating Provider Organizations (PPO's). Each Employee has been assigned a PPO that services the Employee's worksite location. The PPO name, address and phone number will be printed on the Employee's identification card.

The assigned PPO will apply to all Family members regardless of where the individual Family members may reside.

The Plan Administrator will provide each Employee with information regarding his or her PPO.

The following is a list of the Participating Provider Organizations that applies to the Plan; however, only one of these PPO's will apply to each Employee and his or her enrolled Family members.

Employee State of Residence	Participating Provider Organization
NJ, NY, MA, OH, NV, PR **and IL**	PHCS
PA	Beech Street
NC	MedCost
PR	Multiplan

The PPO has an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers. These Participating Providers have agreed to charge reduced fees to Covered Persons covered under the Plan. The Plan saves money because services are performed at a lower cost, the provider gains new clientele, and the Plan Participant receives a cost effective benefit.

Therefore, when a Covered Person uses a Participating Provider, the Covered Person will receive a higher payment from the Plan than when a Non-Participating Provider is used.

It is the Covered Person's option to select a Participating or Non-Participating Provider.

It is the Covered Person's responsibility to verify a provider's current participation as a Participating Provider by calling the PPO number on the ID card or by accessing the website, MyPERFORMAX.com.

Deductibles/Copayments payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person or all Covered Person's in a Family must pay before the Plan will consider expenses for reimbursement. When there is an In-Network and Out-of-Network deductible, the In-Network deductible accrues toward the Out-of-Network deductible and the Out-of-Network deductible accrues toward the In-Network deductible.

An individual deductible is the amount of covered expenses a Covered Person must pay during each calendar year before the Plan will consider expenses for reimbursement. The Family deductible, if applicable, applies collectively to all Covered Persons in a Family each calendar year. When the Family deductible is satisfied, no further deductible will be applied for any covered Family member during the remainder of that calendar year.

A copayment is an amount that a Covered Person pays to his or her provider at the time of service. Copayments do not accrue toward the out-of-pocket maximum.

Out-of-Pocket Maximums

An out-of-pocket maximum is the maximum amount of covered expenses a Covered Person must pay during a calendar year before the Plan payment percentage increases. When there is an In-Network and Out-of-Network out-of-pocket maximum, the In-Network out-of-pocket maximum accrues toward the Out-of-Network out-of-pocket maximum and the Out-of-Network out-of-pocket maximum accrues toward the In-Network out-of-pocket maximum.

The individual out-of-pocket maximum applies separately to each Covered Person. When a Covered Person reaches his or her out-of-pocket maximum, the Plan will pay 100% of additional covered expenses for that individual during the remainder of that calendar year.

The Family out-of-pocket maximum applies collectively to all Covered Persons in the same Family. When the Family out-of-pocket maximum is satisfied, the Plan will pay 100% of covered expenses for any Covered Person in the Family during the remainder of that calendar year.

The Plan will pay the designated percentage of covered charges until the applicable out-of-pocket maximum is reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the calendar year.

The following expenses do not count toward the out-of-pocket maximum and are never paid at 100%:

Inpatient Mental Disorders
Outpatient Mental Disorders
Outpatient substance abuse treatment
Inpatient substance abuse treatment
Cost containment penalties
Copayments
Excess of Usual and Customary Charges
Prescription drug copayments

SCHEDULE OF MEDICAL BENEFITS
GOLD PLAN OPTION

DEDUCTIBLE PER CALENDAR YEAR		MAXIMUM OUT-OF-POCKET PER CALENDAR YEAR	
In-Network	Out-Of-Network	In-Network	Out-Of-Network
$150 per Covered Person $300 per Family	$600 per Covered Person $1,200 per Family	$250 per Covered Person $500 per Family	$3,600 per Covered Person $7,200 per Family

MAXIMUM LIFETIME BENEFIT
(per Covered Person)
$2,000,000

Details regarding Medical Benefits are in the Medical Benefits section.

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS COPAYMENTS	NON-PARTICIPATING PROVIDERS COPAYMENTS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Physician visits	$25	N/A	
Urgent Care Facility	$25	N/A	
Emergency room	$100	$100	The Emergency room copayment is waived if the Covered Person is admitted to the Hospital for a Medical Emergency. PERFORMAX Care Manager must be notified at 1-800-337-0506 within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.
Emergency room services for non-emergency	$500	$500	
Chiropractic/ Acupuncture	$25	N/A	
Substance Abuse	$25	N/A	
Routine Well Adult Visits	$25	N/A	
Routine Well Child Visits	$25	N/A	
Occupational, Physical, Speech and Cognitive Therapy	$25	N/A	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Participating Provider vs. Non-Participating Provider Benefit Level Covered services rendered by a Participating Provider will be paid at the Participating Provider benefit level. Covered services rendered by a Non-Participating Provider will be paid at the Non-Participating Provider benefit level. The Participating Provider benefit level will be paid for Non-Participating Provider services when a: - Covered Person has a Medical Emergency requiring immediate care - Covered Person receives services by a Non-Participating Provider (e.g., anesthesiologists, radiologists, pathologists, etc.) who is under agreement with a Participating facility - Participating Provider submits a specimen to a Non-Participating laboratory - Covered Person receives services from a Participating surgeon who uses a Non-Participating Assistant Surgeon However, all other limitations, requirements and provisions of the Plan will apply including the Usual and Customary provision of the Plan. This exception does not apply in the event of consultations and other situations in which the Covered Person and/or the provider selected had the opportunity to select a Participating Provider, and exercised the right to receive services from a Non-Participating Provider. Referrals by a Participating Provider to a Non-Participating Provider will be considered at the Non-Participating Provider benefit level.			
Maximums Note: The maximums listed below in any one box are the total for Participating and Non-Participating Provider expenses. For example, if a maximum of 60 days is listed in two boxes under a benefit, the calendar year maximum is 60 days total which may be split between Participating and Non-Participating Providers. In addition to the maximums listed above and below, the following maximums apply: - Genetic Testing and Counseling — $2,000 Lifetime maximum - Organ Transplants — $250,000 Lifetime maximum - Sexual Dysfunction/Impotency Counseling — $500 Lifetime maximum - Sleep Disorders (sleep apnea, nocturnal seizures and narcolepsy) — $2,000 Lifetime maximum			
Preventive Care			
Routine Well Adult Care	100% after deductible $500 calendar year maximum	70% U&C after deductible $500 calendar year maximum	Includes: office visits, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests and immunizations/flu shots.
Routine Well Child Care	100% after copayment $500 calendar year maximum	70% U&C after deductible $500 calendar year maximum	Includes: office visits, routine physical examination, laboratory blood tests, x-rays and immunizations until age 6.

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
X-Ray & Laboratory Services			
Cancer Screening: Pap Smear, Prostate blood test, Bilateral Mammogram and Fecal Occult screening	100%	100% U&C	This benefit applies to one of each test including the reading charge, per calendar year. Additional testing which is Medically Necessary will be considered as outlined under Diagnostic Charges. This benefit is in addition to any routine well adult care benefit maximums. Examinations will be considered under the Cancer Screening benefit.
Pre-Admission and Pre-Surgical Testing, within seven (7) days of a scheduled Inpatient Hospital admission.	100%	100% U&C	Failure to have pre-admission or pre-surgical testing done on an outpatient basis will result in non-payment of room and board charges for the first day of confinement. This penalty does not apply to the out-of-pocket maximum.
Diagnostic Charges (X-ray and Laboratory)	90% after deductible	70% U&C after deductible	
Hospital Services, Specialized Treatment Facilities and Services			
Inpatient Hospital Services, including Room and Board	90% after deductible room and board limited to the semiprivate room rate	70% U&C after deductible room and board limited to the semiprivate room rate	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Intensive Care Unit	90% after deductible room and board limited to the ICU/CCU room rate	70% U&C after deductible room and board limited to the ICU/CCU room rate	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Routine Well Newborn Care	90% after deductible	70% U&C after deductible	
Outpatient Hospital	90% after deductible	70% U&C after deductible	
Birthing Center	100%	100% U&C	
Home Health Care	90% after deductible 100 visit calendar year maximum	70% U&C after deductible 100 visit calendar year maximum	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Hospice Care	90% after deductible 210 day/visit inpatient and outpatient Lifetime maximum	70% U&C after deductible 210 day/visit inpatient and outpatient Lifetime maximum	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Hospice Bereavement Counseling	90% after deductible	70% U&C after deductible	Limited to six (6) visits per Hospice treatment.
Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility	90% after deductible room and board limited to the facility's semiprivate room rate 60 day calendar year maximum	70% U&C after deductible room and board limited to the facility's semiprivate room rate 60 day calendar year maximum	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Emergency Services			
Ambulance Service	N/A Participating Providers not available	100% U&C	
Emergency Room, including all related services performed during the same visit.	90% after copayment	90% U&C after copayment	The Emergency room copayment is waived if the Covered Person is admitted to the Hospital for a Medical Emergency. PERFORMAX Care Manager must be notified at 1-800-337-0506 within 48 hours of the admission, even if the Covered Person is discharged within 48 hours of the admission.
Emergency Room (Non-Emergency)	90% after copayment	90% U&C after copayment	
Urgent Care Facility	100% after copayment	70% U&C after deductible	
Medical and Surgical Physician Services			
Allergy Serum and Injections	90% after deductible	70% U&C after deductible	
Spinal Manipulation/ Chiropractic and Acupuncture	100% after copayment 30 visit or $1,000 per calendar year, whichever comes first maximum, whichever comes first	Not Covered	Maximum includes related x-ray and laboratory services.
Inpatient and Outpatient Private Duty Nursing	90% after deductible 60 visit calendar year maximum	70% U&C after deductible 60 visit calendar year maximum	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Inpatient Surgery (Includes anesthesiologists)	90% after deductible	70% U&C after deductible	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Outpatient Surgery (Includes anesthesiologists)	90% after deductible	70% U&C after deductible	The Plan's payment will be reduced if the requirements of the Health Care Management section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Surgery performed in a Physician's office	100% after copayment	70% U&C after deductible	Pre-certification is not required.
Inpatient Physician visits	90% after deductible	70% U&C after deductible	
Occupational Therapy	100% after copayment 45 visit calendar year maximum	70% U&C after deductible 45 visit calendar year maximum	Calendar year maximum combined with Physical Therapy.
Physical Therapy	100% after copayment 45 visit calendar year maximum	70% U&C after deductible 45 visit calendar year maximum	Calendar year maximum combined with Occupational Therapy.
Speech Therapy and Cognitive Therapy	100% after copayment 45 visit calendar year maximum	70% U&C after deductible 45 visit calendar year maximum	
Physician's Office/Home visits	100% after copayment	70% U&C after deductible	Includes diagnostic services performed in the Physician's Office.
Second Surgical Opinion	100%	100% U&C	
Smoking Cessation Benefit	100% $500 Lifetime maximum	100% U&C $500 Lifetime maximum	For all Plan Participants
All Other Covered Medical and Surgical Expenses	90% after deductible	70% U&C after deductible	
Durable Medical Equipment, Supplies, Prosthetics and Orthotics			
Durable Medical Equipment	90% after deductible	70% U&C after deductible	
Medical Supplies	90% after deductible	70% U&C after deductible	
Prosthetics and Orthotics	90% after deductible	70% U&C after deductible	
Wig After Chemotherapy	90% after deductible	70% U&C after deductible	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Mental Disorders and Substance Abuse			
Inpatient Mental Disorders	90% after deductible 30 day calendar year maximum	70% U&C after deductible 30 day calendar year maximum	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum. Two days of Partial Hospitalization equal one inpatient day.
Inpatient Substance Abuse Treatment	90% after deductible $10,000 calendar year maximum and $25,000 Lifetime maximum	70% U&C after deductible $10,000 calendar year maximum and $25,000 Lifetime maximum	Calendar year and Lifetime maximums are combined with Outpatient Substance Abuse Treatment calendar year and Lifetime maximums. The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum. Two days of Partial Hospitalization equal one inpatient day.
Outpatient Mental Disorders	100% after copayment 30 visit calendar year maximum	70% U&C after deductible 30 visit calendar year maximum	Includes certain Family Counseling and Marital Counseling.
Outpatient Substance Abuse Treatment	100% after copayment $10,000 calendar year maximum and $25,000 Lifetime maximum	70% U&C after deductible $10,000 calendar year maximum and $25,000 Lifetime maximum	Calendar year and Lifetime maximums are combined with Inpatient Substance Abuse Treatment calendar year and Lifetime maximums. Includes certain Family Counseling and Marital Counseling.

SCHEDULE OF MEDICAL BENEFITS
PLATINUM PLAN OPTION

DEDUCTIBLE PER CALENDAR YEAR		MAXIMUM OUT-OF-POCKET PER CALENDAR YEAR	
In-Network	Out-Of-Network	In-Network	Out-Of-Network
N/A	N/A	N/A	N/A

MAXIMUM LIFETIME BENEFIT
(per Covered Person)
$2,000,000

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Participating Provider vs. Non-Participating Provider Benefit Level Covered services rendered by a Participating Provider will be paid at the Participating Provider benefit level. Covered services rendered by a Non-Participating Provider will be paid at the Non-Participating Provider benefit level. The Participating Provider benefit level will be paid for Non-Participating Provider services when a: - Covered Person has a Medical Emergency requiring immediate care - Covered Person receives services by a Non-Participating Provider (e.g., anesthesiologists, radiologists, pathologists, etc.) who is under agreement with a Participating facility - Participating Provider submits a specimen to a Non-Participating laboratory - Covered Person receives services from a Participating surgeon who uses a Non-Participating Assistant Surgeon However, all other limitations, requirements and provisions of the Plan will apply including the Usual and Customary provision of the Plan. This exception does not apply in the event of consultations and other situations in which the Covered Person and/or the provider selected had the opportunity to select a Participating Provider, and exercised the right to receive services from a Non-Participating Provider. Referrals by a Participating Provider to a Non-Participating Provider will be considered at the Non-Participating Provider benefit level.			
Maximums Note: The maximums listed below in any one box are the total for Participating and Non-Participating Provider expenses. For example, if a maximum of 60 days is listed in two boxes under a benefit, the calendar year maximum is 60 days total which may be split between Participating and Non-Participating Providers. In addition to the maximums listed above and below, the following maximums apply: - Genetic Testing and Counseling — $2,000 Lifetime maximum - Organ Transplants — $250,000 Lifetime maximum - Sexual Dysfunction/Impotency Counseling — $500 Lifetime maximum - Sleep Disorders (sleep apnea, nocturnal seizures and narcolepsy) — $2,000 Lifetime maximum			
Preventive Care			
Routine Well Adult Care	100% $500 calendar year maximum	100% U&C $500 calendar year maximum	Includes: office visits, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests and immunizations/flu shots.
Routine Well Child Care	100% $500 calendar year maximum	100% U&C $500 calendar year maximum	Includes: office visits, routine physical examination, laboratory blood tests, x-rays and immunizations until age 6.

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
X-Ray & Laboratory Services			
Cancer Screening: Pap Smear, Prostate blood test, Bilateral Mammogram and Fecal Occult screening	100%	100% U&C	This benefit applies to one of each test including the reading charge, per calendar year. Additional testing which is Medically Necessary will be considered as outlined under Diagnostic Charges. This benefit is in addition to any routine well adult care benefit maximums. Examinations will be considered under the Cancer Screening benefit.
Pre-Admission and Pre-Surgical Testing, within seven (7) days of a scheduled Inpatient Hospital admission.	100%	100% U&C	Failure to have pre-admission or pre-surgical testing done on an outpatient basis will result in non-payment of room and board charges for the first day of confinement. This penalty does not apply to the out-of-pocket maximum.
Diagnostic Charges (X-ray and Laboratory)	100%	100% U&C	
Hospital Services, Specialized Treatment Facilities and Services			
Inpatient Hospital Services, including Room and Board	100% room and board limited to the semiprivate room rate	100% U&C room and board limited to the semiprivate room rate	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Intensive Care Unit	100% room and board limited to the ICU/CCU room rate	100% U&C room and board limited to the ICU/CCU room rate	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Routine Well Newborn Care	100%	100% U&C	
Outpatient Hospital	100%	100% U&C	
Birthing Center	100%	100% U&C	
Home Health Care	100% 100 visit calendar year maximum	100% U&C 100 visit calendar year maximum	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Hospice Care	100% 210 day/visit inpatient and outpatient Lifetime maximum	100% U&C 210 day/visit inpatient and outpatient Lifetime maximum	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Hospice Bereavement Counseling	100%	100% U&C	Limited to six (6) visits per Hospice treatment.
Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility	100% room and board limited to the facility's semiprivate room rate 60 day calendar year maximum	100% U&C room and board limited to the facility's semiprivate room rate 60 day calendar year maximum	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Emergency Services			
Ambulance Service	N/A Participating Providers not available	100% U&C	
Emergency Room, including all related services performed during the same visit.	100%	100% U&C	PERFORMAX Care Manager must be notified at 1-800-337-0506 within 48 hours of the admission, even if the Covered Person is discharged within 48 hours of the admission.
Emergency Room (Non-Emergency)	100%	100% U&C	
Urgent Care Facility	100%	100% U&C	
Medical and Surgical Physician Services			
Allergy Serum and Injections	100%	100% U&C	
Spinal Manipulation/ Chiropractic and Acupuncture	100% 30 visit or $1,000 per calendar year, whichever comes first maximum	Not Covered	Maximum includes related x-ray and laboratory services.
Inpatient and Outpatient Private Duty Nursing	100% 60 visit calendar year maximum	100% U&C 60 visit calendar year maximum	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Inpatient Surgery (Includes anesthesiologists)	100%	100% U&C	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Outpatient Surgery (Includes anesthesiologists)	100%	100% U&C	The Plan's payment will be reduced if the requirements of the Health Care Management section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Surgery performed in a Physician's office	100%	100% U&C	Pre-certification is not required.
Inpatient Physician visits	100%	100% U&C	
Occupational Therapy	100% 45 visit calendar year maximum	100% U&C 45 visit calendar year maximum	Calendar year maximum combined with Physical Therapy.
Physical Therapy	100% 45 visit calendar year maximum	100% U&C 45 visit calendar year maximum	Calendar year maximum combined with Occupational Therapy.
Speech Therapy and Cognitive Therapy	100% 45 visit calendar year maximum	100% U&C 45 visit calendar year maximum	
Physician's Office/Home visits	100%	100% U&C	Includes diagnostic services performed in the Physician's Office.
Second Surgical Opinion	100%	100% U&C	
Smoking Cessation Benefit	100% $500 Lifetime maximum	100% U&C $500 Lifetime maximum	For all Plan Participants
All Other Covered Medical and Surgical Expenses	100%	100% U&C	
Durable Medical Equipment, Supplies, Prosthetics and Orthotics			
Durable Medical Equipment	100%	100% U&C	
Medical Supplies	100%	100% U&C	
Prosthetics and Orthotics	100%	100% U&C	
Wig After Chemotherapy	100%	100% U&C	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Mental Disorders and Substance Abuse			
Inpatient Mental Disorders	100% 30 day calendar year maximum	100% U&C 30 day calendar year maximum	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum. Two days of Partial Hospitalization equal one inpatient day.
Inpatient Substance Abuse Treatment	100% $10,000 calendar year maximum and $25,000 Lifetime maximum	100% U&C $10,000 calendar year maximum and $25,000 Lifetime maximum	Calendar year and Lifetime maximums are combined with Outpatient Substance Abuse Treatment calendar year and Lifetime maximums. The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum. Two days of Partial Hospitalization equal one inpatient day.
Outpatient Mental Disorders	100% 30 visit calendar year maximum	100% U&C 30 visit calendar year maximum	Includes certain Family Counseling and Marital Counseling.
Outpatient Substance Abuse Treatment	100% $10,000 calendar year maximum and $25,000 Lifetime maximum	100% U&C $10,000 calendar year maximum and $25,000 Lifetime maximum	Calendar year and Lifetime maximums are combined with Inpatient Substance Abuse Treatment calendar year and Lifetime maximums. Includes certain Family Counseling and Marital Counseling.

SCHEDULE OF MEDICAL BENEFITS
SILVER PLAN OPTION

DEDUCTIBLE PER CALENDAR YEAR		MAXIMUM OUT-OF-POCKET PER CALENDAR YEAR	
In-Network	Out-Of-Network	In-Network	Out-Of-Network
$2,500 per Covered Person $3,500 per Employee plus Spouse $3,500 per Employee plus children $5,000 per Family	$2,500 per Covered Person $3,500 per Employee plus Spouse $3,500 per Employee plus children $5,000 per Family	$3,000 per Covered Person $4,000 per Employee plus Spouse $4,000 per Employee plus children $5,500 per Family	$6,000 per Covered Person $9,000 per Employee plus Spouse $9,000 per Employee plus children $12,000 per Family

MAXIMUM LIFETIME BENEFIT
(per Covered Person)
$2,000,000

Details regarding Medical Benefits are in the Medical Benefits section.

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS COPAYMENTS	NON-PARTICIPATING PROVIDERS COPAYMENTS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Physician visits	$25	N/A	
Urgent Care Facility	$25	N/A	
Emergency room	$100	$100	The Emergency room copayment is waived if the Covered Person is admitted to the Hospital for a Medical Emergency. PERFORMAX Care Manager must be notified at 1-800-337-0506 within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.
Emergency room services for non-emergency	$500	$500	
Chiropractic/ Acupuncture	$25	N/A	
Substance Abuse	$25	N/A	
Routine Well Adult Visits	$25	N/A	
Routine Well Child Visits	$25	N/A	
Occupational, Physical, Speech and Cognitive Therapy	$25	N/A	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Participating Provider vs. Non-Participating Provider Benefit Level Covered services rendered by a Participating Provider will be paid at the Participating Provider benefit level. Covered services rendered by a Non-Participating Provider will be paid at the Non-Participating Provider benefit level. The Participating Provider benefit level will be paid for Non-Participating Provider services when a: - Covered Person has a Medical Emergency requiring immediate care - Covered Person receives services by a Non-Participating Provider (e.g., anesthesiologists, radiologists, pathologists, etc.) who is under agreement with a Participating facility - Participating Provider submits a specimen to a Non-Participating laboratory - Covered Person receives services from a Participating surgeon who uses a Non-Participating Assistant Surgeon However, all other limitations, requirements and provisions of the Plan will apply including the Usual and Customary provision of the Plan. This exception does not apply in the event of consultations and other situations in which the Covered Person and/or the provider selected had the opportunity to select a Participating Provider, and exercised the right to receive services from a Non-Participating Provider. Referrals by a Participating Provider to a Non-Participating Provider will be considered at the Non-Participating Provider benefit level.			
Maximums Note: The maximums listed below in any one box are the total for Participating and Non-Participating Provider expenses. For example, if a maximum of 60 days is listed in two boxes under a benefit, the calendar year maximum is 60 days total which may be split between Participating and Non-Participating Providers. In addition to the maximums listed above and below, the following maximums apply: - Genetic Testing and Counseling — $2,000 Lifetime maximum - Organ Transplants — $250,000 Lifetime maximum - Sexual Dysfunction/Impotency Counseling — $500 Lifetime maximum - Sleep Disorders (sleep apnea, nocturnal seizures and narcolepsy) — $2,000 Lifetime maximum			
Preventive Care			
Routine Well Adult Care	100% after copayment $500 calendar year maximum	70% U&C after deductible $500 calendar year maximum	Includes: office visits, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests and immunizations/flu shots.
Routine Well Child Care	100% after copayment $500 calendar year maximum	70% U&C after deductible $500 calendar year maximum	Includes: office visits, routine physical examination, laboratory blood tests, x-rays and immunizations until age 6.

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
X-Ray & Laboratory Services			
Cancer Screening: Pap Smear, Prostate blood test, Bilateral Mammogram and Fecal Occult screening	100%	100% U&C	This benefit applies to one of each test including the reading charge, per calendar year. Additional testing which is Medically Necessary will be considered as outlined under Diagnostic Charges. This benefit is in addition to any routine well adult care benefit maximums. Examinations will be considered under the Cancer Screening benefit.
Pre-Admission and Pre-Surgical Testing, within seven (7) days of a scheduled Inpatient Hospital admission.	100%	100% U&C	Failure to have pre-admission or pre-surgical testing done on an outpatient basis will result in non-payment of room and board charges for the first day of confinement. This penalty does not apply to the out-of-pocket maximum.
Diagnostic Charges (X-ray and Laboratory)	90%	70% U&C after deductible	
Hospital Services, Specialized Treatment Facilities and Services			
Inpatient Hospital Services, including Room and Board	90% after deductible room and board limited to the semiprivate room rate	70% U&C after deductible room and board limited to the semiprivate room rate	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Intensive Care Unit	90% after deductible room and board limited to the ICU/CCU room rate	70% U&C after deductible room and board limited to the ICU/CCU room rate	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Routine Well Newborn Care	90% after deductible	70% U&C after deductible	
Outpatient Hospital	90% after deductible	70% U&C after deductible	
Birthing Center	100%	100% U&C	
Home Health Care	90% after deductible	70% U&C after deductible	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Hospice Care	90% after deductible 210 day/visit inpatient and outpatient Lifetime maximum	70% U&C after deductible 210 day/visit inpatient and outpatient Lifetime maximum	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Hospice Bereavement Counseling	90% after deductible	70% U&C after deductible	Limited to six (6) visits per Hospice treatment.
Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility	90% after deductible room and board limited to the facility's semiprivate room rate 60 day calendar year maximum	70% U&C after deductible room and board limited to the facility's semiprivate room rate 60 day calendar year maximum	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Emergency Services			
Ambulance Service	N/A Participating Providers not available	100% U&C	
Emergency Room, including all related services performed during the same visit.	90% after copayment	90% U&C after copayment	The Emergency room copayment is waived if the Covered Person is admitted to the Hospital for a Medical Emergency. PERFORMAX Care Manager must be notified at 1-800-337-0506 within 48 hours of the admission, even if the Covered Person is discharged within 48 hours of the admission.
Emergency Room (Non-Emergency)	90% after copayment	90% U&C after copayment	
Urgent Care Facility	100% after copayment	70% U&C after deductible	
Medical and Surgical Physician Services			
Allergy Serum and Injections	90%	70% U&C after deductible	
Spinal Manipulation/ Chiropractic and Acupuncture	100% after copayment 30 visit or $1,000 per calendar year, whichever comes first maximum	Not Covered	Maximum includes related x-ray and laboratory services.
Inpatient and Outpatient Private Duty Nursing	90% after deductible 60 visit calendar year maximum	70% U&C after deductible 60 visit calendar year maximum	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Inpatient Surgery (Includes anesthesiologists)	90% after deductible	70% U&C after deductible	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Outpatient Surgery (Includes anesthesiologists)	90% after deductible	70% U&C after deductible	The Plan's payment will be reduced if the requirements of the Health Care Management section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Surgery performed in a Physician's office	100% after copayment	70% U&C after deductible	Pre-certification is not required.
Inpatient Physician visits	90% after deductible	70% U&C after deductible	
Occupational Therapy	100% after copayment 45 visit calendar year maximum	70% U&C after deductible 45 visit calendar year maximum	Calendar year maximum combined with Physical Therapy.
Physical Therapy	100% after copayment 45 visit calendar year maximum	70% U&C after deductible 45 visit calendar year maximum	Calendar year maximum combined with Occupational Therapy.
Speech Therapy and Cognitive Therapy	100% after copayment 45 visit calendar year maximum	70% U&C after deductible 45 visit calendar year maximum	
Physician's Office/Home visits	100% after copayment	70% U&C after deductible	Includes diagnostic services performed in the Physician's Office.
Second Surgical Opinion	100%	100% U&C	
Smoking Cessation Benefit	100% $500 Lifetime maximum	100% U&C $500 Lifetime maximum	For all Plan Participants
All Other Covered Medical and Surgical Expenses	90% after deductible	70% U&C after deductible	
Durable Medical Equipment, Supplies, Prosthetics and Orthotics			
Durable Medical Equipment	90% after deductible	70% U&C after deductible	
Medical Supplies	90% after deductible	70% U&C after deductible	
Prosthetics and Orthotics	90% after deductible	70% U&C after deductible	
Wig After Chemotherapy	90% after deductible	70% U&C after deductible	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Mental Disorders and Substance Abuse			
Inpatient Mental Disorders	90% after deductible 30 day calendar year maximum	70% U&C after deductible 30 day calendar year maximum	The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum. Two days of Partial Hospitalization equal one inpatient day.
Inpatient Substance Abuse Treatment	90% after deductible $10,000 calendar year maximum and $25,000 Lifetime maximum	70% U&C after deductible $10,000 calendar year maximum and $25,000 Lifetime maximum	Calendar year and Lifetime maximums are combined with Outpatient Substance Abuse Treatment calendar year and Lifetime maximums. The Plan's payment will be reduced if the requirements of the PERFORMAX Care Manager Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum. Two days of Partial Hospitalization equal one inpatient day.
Outpatient Mental Disorders	100% after copayment 30 visit calendar year maximum	70% U&C after deductible 30 visit calendar year maximum	Includes certain Family Counseling and Marital Counseling.
Outpatient Substance Abuse Treatment	100% after copayment $10,000 calendar year maximum and $25,000 Lifetime maximum	70% U&C after deductible $10,000 calendar year maximum and $25,000 Lifetime maximum	Calendar year and Lifetime maximums are combined with Inpatient Substance Abuse Treatment calendar year and Lifetime maximums. Includes certain Family Counseling and Marital Counseling.

SCHEDULE OF PRESCRIPTION DRUG BENEFIT
GOLD AND SILVER PLAN OPTIONS

BENEFIT DESCRIPTION	
Pharmacy Option (30-day supply)	**Copayment**
Generic drugs	$10
Formulary Brand Name drugs with no Generic equivalent	$25
Brand Name Drugs with Generic equivalent	$50
Mail Order Prescription Drug Option (90-day supply)	**Copayment**
Generic drugs	$30
Brand Name drugs with no Generic equivalent	$75
Brand name drugs with Generic equivalent	$150
Limitations	
Sexual Dysfunction Drug Therapy, limited to $750 calendar year maximum	

Details regarding Prescription Drug Benefits are in the Prescription Drug Benefits section.

SCHEDULE OF PRESCRIPTION DRUG BENEFIT
PLATINUM PLAN OPTION

BENEFIT DESCRIPTION	
Pharmacy Option (30-day supply)	**Copayment**
Generic drugs	$0
Formulary Brand Name drugs	$0
Non-Formulary Brand Name drugs	$0
Mail Order Prescription Drug Option (90-day supply)	**Copayment**
Generic drugs	$0
Formulary Brand Name drugs	$0
Non-Formulary Brand Name drugs	$0
Limitations	
Sexual Dysfunction Drug Therapy, limited to $750 calendar year maximum	

Details regarding Prescription Drug Benefits are in the Prescription Drug Benefits section.

SCHEDULE OF VISION CARE BENEFITS
ALL OPTIONS

BENEFIT DESCRIPTION	BENEFIT
Vision Benefits are limited to the following:	
Eye exam and Vision hardware, per Covered Person, per calendar year (Includes: Frames, Frame – type lenses and contact lenses)	$200

Details regarding Vision Benefits are in the Vision Benefits section.

SCHEDULE OF DENTAL BENEFITS
ALL OPTIONS

Calendar Year Deductible:

$100 per Covered Person
$200 per Family

The Calendar Year Deductible Applies to the Following Classes of Services:

Class B Services - Basic
Class C Service - Major
Class D Services - Orthodontia

BENEFIT DESCRIPTION	BENEFIT
Maximum Benefit Amount	
For all classes other than Class D-Orthodontia: Per Covered Person per calendar year	$1,500
For Class D-Orthodontia: (available for covered Dependent children under age 19) Lifetime maximum per Covered Person	$1,500
Dental Percentage Payable	
Class A Services-Preventive	80% of U&C
Class B Services-Basic	60% of U&C
Class C Services-Major	50% of U&C
Class D Services-Orthodontia	50% of U&C

A written proposed course of treatment for any procedure estimated to be over $300 should be submitted by the Dentist for review prior to the actual performance of services. Evaluation of the course of treatment is subject to the alternate procedure provision of the Plan and does not guarantee payment of benefits when the actual services are performed.

Details regarding Dental Benefits are in the Dental Benefits section.

DEFINED TERMS

The following terms, when capitalized in the Plan, have the special meanings indicated.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer, as determined by the Employer.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by Registered Nurses (R.N.) and does not provide for overnight stays.

Assistant Surgeon is a Physician who actively assists the Physician in charge of a case in performing a surgical procedure. Depending on the type of surgery to be performed, an operating surgeon may have one or two Assistant Surgeons. The need for an Assistant Surgeon is dictated by the technical aspects of the surgery involved.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where birth occurs in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a Registered Nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Cosmetic means care and treatment performed primarily to improve one's appearance, and does not promote the proper function of the body or prevent or treat an Illness, Injury or disease.

Cosmetic Dentistry means care and treatment performed primarily to improve ones dental appearance.

Covered Person is an Employee or Dependent who is covered under the Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits; long-term care benefits if provided under a separate policy; coverage that is limited to a specified disease or Illness; Hospital indemnity or other fixed dollar indemnity insurance if provided under a separate policy, certificate or contract of insurance; coverage only for accidents; disability income insurance; liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; or, coverage for on-site medical clinics. Days in a waiting period from a prior plan during which an Employee has no other coverage are not considered Creditable Coverage under the Plan, nor are these days taken into account when determining a Significant Break In Coverage.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice dentistry and is practicing within the scope of such license.

Diagnostic Charges means charges for x-ray or laboratory examinations made or ordered by a Physician in order to detect a medical condition.

Disability means the inability to perform all the duties of the Covered Person's occupation as the result of a non-occupational Illness or Injury. For an unemployed Covered Person, Disability means the inability to perform the normal duties of a person of the same age.

Disability (Disabled) for an Active Employee means the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Illness or Injury. Disability will be determined by the attending Physician.

Disability (Disabled) for a Dependent child means incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and the complete inability as a result of Illness or Injury to perform the normal activities of a person of like age and sex in good health.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employer is the Plan Sponsor and any other entity, with the consent of the Plan Sponsor that adopts the Plan.

Endodontic Treatments are procedures for the prevention and treatment of diseases of the dental pulp, pulp chamber, root canal and surrounding periapical structures.

Enrollment Date is the first day of coverage or, if there is a waiting period, the first day of the waiting period.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. A drug, device, medical treatment or procedure is Experimental and/or Investigational:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials, is the research, experimental, study or Investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating provider or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another provider studying substantially the same drug, device, medical treatment or procedure that states it is Experimental, Investigational, educational, for a research study, or posing an uncertain outcome or having an unusual risk.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for the specific Injury or Illness to be treated.

Family is an Employee who is a Covered Person and his or her Dependents who are Covered Persons.

Formulary means a list of prescription medications specified as such by the Plan Administrator.

Generic drug means any Food and Drug Administration approved Generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being Generic.

Harmful Habit shall for the purpose of the Plan be the acquired habit of thumb sucking, tongue thrusting or bruxism, which causes damage to the teeth and/or periodontal support.

Hazardous Pursuit is an activity, which in the judgment of the Plan Administrator, involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of occupations or leisure time activities commonly considered as not involving excessive risk.

Such activities for the purposes of the Plan only, are limited to the following: hang gliding, sky diving, outdoor rock climbing, motorcycle racing, automobile racing, speedboat racing, bungee jumping, ice climbing and ultra-light flying.

Home Health Care Agency is an organization that provides Home Health Care Services and Supplies; is federally certified as a Home Health Care Agency; and is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan is a formal written plan made by the patient's attending Physician. It must state the diagnosis and must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is a public or private organization, licensed and operated according to the law, primarily engaged in providing Hospice Care Services and Supplies for palliative, supportive, and other related care for a Covered Person diagnosed as terminally ill with a medical prognosis that life expectancy is 6 months or less.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and Family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these requirements: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

"Hospital" also includes:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these requirements: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a non-occupational bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage, as defined by the Employer.

Infertility means incapable of producing offspring.

Injury means a non-occupational accidental physical injury caused by an unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill and which has facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is used in the Plan in reference to benefit maximums and limitations and is understood to mean while covered under the Plan effective December 1, 2005.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means an Illness or Injury which occurs suddenly and unexpectedly, requiring immediate medical care and use of the most accessible Hospital equipped to furnish care to prevent the death or serious impairment of the Covered Person.

Such conditions include but are not limited to suspected heart attack, loss of consciousness, actual or suspected poisoning, acute appendicitis, heat exhaustion, convulsions, emergency medical care rendered in accident cases and other acute conditions.

Medically or Dentally Necessary means the treatment is generally accepted by medical professionals in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

"Proven" means the care is not considered Experimental/Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA), for treatment.

"Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, injury, illness or a clinical condition.

"Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the The Challenge Printing Company Employee Benefit Plan.

All criteria must be satisfied. When a Physician merely recommends or approves certain care does not mean that it is Medically Necessary.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Non-Participating (Out-of-Network) Provider means a Hospital, Physician or other health care provider that has not entered into a contractual agreement with the Plan's Participating Provider Organization (PPO).

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a Covered Person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Partial Hospitalization is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours, a day and no charge is made for room and board.

Participating (In-Network) Provider means a Hospital, Physician or other health care provider that has a contractual agreement with the Plan's Participating Provider Organization (PPO).

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician (Health care Provider) means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Acupuncturist, Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, Nutritionist/Dietician and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan Participant is any Employee or Dependent who is covered under the Plan.

Plan Sponsor is The Challenge Printing Co., Inc., as further identified under General Plan Information.

Plan Year refer to the General Plan Information page.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's Enrollment Date under the Plan.

Pregnancy is not considered a Pre-Existing Condition. Also, any Plan exclusion for coverage of Pre-Existing Conditions does not apply to a newborn child who is covered under the Plan or under other creditable coverage within 30 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, any time during the 30-day period beginning on the date of the adoption or placement for adoption, is covered under the Plan or under other Creditable Coverage. A Pre-Existing Condition exclusion may apply with regard to periods before the date of the adoption or placement for adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after Significant Break in Coverage that follows the birth adoption or placement for adoption.

Pregnancy is childbirth and conditions associated with Pregnancy, including Complications of Pregnancy.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes.

Qualified Medical Child Support Order (QMCSO) is a judgment or decree by a court of competent jurisdiction or order issued through an administrative process established under state law that has the force and effect of state law that requires the Plan to provide coverage to the children of an Employee pursuant to a state domestic relations law.

A medical child support order must meet certain requirements specified in the law in order to be considered "qualified."

Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Illness or Injury.

Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Illness or Injury.

Significant Break in Coverage is a period of 63 consecutive days during all of which the individual does not have any Creditable Coverage, except that a waiting period is not taken into account in determining a Significant Break in Coverage.

Skilled Nursing Facility, including an extended care facility and a rehabilitation facility, is a facility that fully meet all of the following:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse means the person of the opposite sex recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Urgent Care Facility is a public or private facility, licensed and operated according to the law, which provides immediate care in the case of a Medical Emergency or accidental Injury. Treatment must be administered under the supervision of a recognized Physician or nurse as defined in the Plan and the facility must maintain relationship with an available pool of specialists for consultation and treatment when necessary.

The facility cannot provide any inpatient treatment and cannot be accessed for routine care, non-emergencies or as a private practice.

Usual and Customary Charge is a charge which is not more than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of that care or supply in the same area, as determined by the Plan Administrator. The nature and severity of the condition being treated will be considered. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

If the actual charge billed is less than the Usual and Customary Charge as defined above the lesser charge billed will be deemed to be the Usual and Customary Charge.

ELIGIBILITY AND COMMENCEMENT OF COVERAGE PROVISIONS

ELIGIBILITY

Eligible Classes of Employees. An Employee of the Employer who is a United States citizen and non-citizen with a valid work visa and is:

(1) a full-time Employee regularly scheduled to work at least 34 hours per week for the Employer (as determined by the Employer) and is on the regular payroll of the Employer.

Waiting period for Employee coverage.

An Employee must:

(1) complete the waiting period of six months as an Active Employee. Please see section titled Effective Date of Coverage to determine when coverage begins after the waiting period. For the purpose of this provision, if the Employee is absent from work because of a health condition, any service performed immediately before that absence (and not interrupted by any other type of absence) will apply toward the requirement and will be added toward any service completed (and not interrupted by any other type of absence) after the absence ends. The waiting period is counted toward the Pre-Existing Conditions exclusion provision of the Plan.

Should an Employee of the Employer change to full-time status, any waiting period required to be eligible for coverage under the The Challenge Printing Company Employee Benefit Plan will be calculated from the Employee's date of hire. If the Employee has been employed with the Employer longer than the required waiting period, coverage would begin on the first day of the month following the date the Employee changed to full-time status.

Notwithstanding the foregoing, the term Employee shall not include:

(1) any Employee of the Employer who is a member of a collective bargaining unit covered under a collective bargaining agreement unless the collective bargaining agreement provides for the Employee's participation in the Plan, or

(2) any leased employee of the Employer, or

(3) any person who is not classified by the Employer as a common law employee of the Employer for the period during which the person is not so classified by the Employer notwithstanding the later reclassification by a court or any regulatory agency of the person as a common law employee of the Employer or

(4) any person classified by the Employer as a temporary employee of the Employer (as determined by the Employer).

Effective Date of Employee Coverage. When the enrollment requirements are met, an eligible Employee's coverage is effective on the first day of the month following the waiting period. In the case of a Special Enrollment Situation or Status Change, coverage will be effective on the date of the event, provided the enrollment application is received within 30 days of the event.

An Employee must be an Active Employee (as defined by the Plan) for coverage to begin.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse, unless legally separated and unmarried children from birth to the limiting age of 19 years, who are residing in the United States of America. The Dependent children must be primarily dependent upon the covered Employee for support for the purpose of Section 152

of the Internal Revenue Code. However, a Dependent child will continue to be covered after age 19, provided the child is a full-time student at an accredited school, primarily dependent upon the covered Employee for support, unmarried and under the limiting age of 25. When the child reaches either limiting age, coverage will end on the last day of the child's birthday month. If the child does not maintain full-time student status or graduates, coverage terminates independent of the limiting age.

Full-time student coverage continues only between terms if the student is enrolled as a full-time student in the next regular term. If the student is not enrolled as a full-time student in the next regular term, coverage will be terminated retroactively to the last day of the attended school term. The Employer has the right to recover benefit payments made during a semester break if the Dependent fails to return to school as a full-time student the following term.

The term "Spouse" shall mean the person of the opposite sex recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" means natural children of the Employee, legally adopted children who are under age 18 at the time of the adoption or children under age 18 who are placed with a covered Employee in anticipation of adoption. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee.

If a covered Employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in the Plan as covered Dependents.

If the Plan Administrator determines that a child was placed under the care of a covered Employee pursuant to a court order or other legal proceeding, and if the child is primarily dependent upon the covered Employee for support, the child will be treated as a child of the covered Employee for all purposes of this Plan and will continue to be treated as a child of the covered Employee for as long as they are primarily dependent upon the covered Employee for support; regardless, that the child has attained age 18 (or other applicable age of emancipation of minors) and therefore, under the terms of the original court order, is no longer under the legal custody of the covered Employee. However, the child will be subject to meeting all other age limitations and full-time student requirements of the Plan.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a Qualified Medical Child Support Order shall be considered as having a right to Dependent coverage under the Plan in the manner described in ERISA §609(a) and the Plan's QMCSO procedures.

A participant of the Plan may obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator.

The phrase "primarily dependent upon" shall mean dependent upon the covered Employee for support as defined by the Internal Revenue Code and the covered Employee must declare the child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(2) A covered Dependent child who reaches the limiting age and is Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the

covered Employee for support, unmarried and does not qualify for any other health coverage. The Plan Administrator may require subsequent proof of the child's Disability and dependency, including a Physician's statement certifying the child's physical or mental incapacity.

The following are excluded as Dependents: any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under the Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under the Plan, during and after the change in status, credit will be given toward deductibles and all amounts applied to Plan maximums.

If both mother and father are Employees of the Employer, their children will be covered as Dependents of the mother or father, but not of both.

Effective Date of Dependent Coverage. Dependent coverage is effective on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all enrollment requirements are met. In the case of a Special Enrollment Situation or Status Change, coverage will be effective on the date of the event, provided the enrollment application is received within 30 days of the event.

PRE-EXISTING CONDITIONS

NOTE: The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if a Covered Person has Creditable Coverage from another health plan.

A Covered Person may request a certificate of Creditable Coverage from his or her prior plan within 24 months after losing coverage.

After Creditable Coverage has been taken into account, and the Plan has determined that a Pre-Existing Conditions Limitation applies to a Covered Person, the Covered Person will be notified by the earliest date that the plan, acting in a reasonable and prompt fashion, can provide the notice..

Except as otherwise provided in the Plan, covered charges incurred under Medical Benefits for Illnesses or Injuries that are determined to be Pre-Existing Conditions are excluded for the first 12 consecutive months, or 18 months for a Late Enrollee, after the Covered Person's Enrollment Date.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by completing, signing and timely submitting an enrollment application along with the appropriate payroll deduction authorization. If the Employee wishes to enroll eligible Dependents, the enrollment application and payroll deduction authorization must include Dependent information.

Enrollment Requirements for Newborn Children

A newborn child must be enrolled as a Dependent under the Plan within 30 days of the child's birth in order for coverage to take effect from the date of birth.

If the child is required to be enrolled and is not enrolled within 30 days of birth, the child may only enroll during the annual open enrollment period. The enrollment will be considered a Late Enrollment.

TIMELY INITIAL ENROLLMENT

Initial enrollment is considered "timely" if the completed enrollment form is received by the Plan Administrator no later than 30 days after the person becomes eligible for coverage under the Plan, initially or under a Special Enrollment Situation.

When two Employees (husband and wife) are covered under the Plan and the Employee covering the Dependent children is no longer eligible for coverage under the Plan, Dependent coverage may continue under the other Covered Employee with no waiting period. However, coverage must be continuous from one Employee to the other.

SPECIAL ENROLLMENT SITUATION/STATUS CHANGE

An Employee or Dependent may be eligible to enroll for coverage under the Plan during a Special Enrollment Period. There are two types of Special Enrollment Periods, as described below. For either type of Special Enrollment, an Employee who has a Special Enrollment Right (for the Employee or one or more Dependents) may elect coverage under any Plan option that is available to an Employee during an initial enrollment opportunity, as long as the Employee (or Dependent) is otherwise eligible for that Plan option.:

(1) **Special Enrollment Rights because of loss of other coverage.** An Employee or Dependent is eligible for coverage under the Plan, but chose not to enroll in the Plan, because he or she was covered at the time coverage under the Plan was previously offered may enroll later if one of the following conditions is met:

(a) The other coverage was not COBRA coverage and that coverage terminates because of a Loss of Eligibility, (as described below);.

(b) The other coverage was not COBRA coverage and an employer's contributions towards the coverage cease; or

(c) The coverage of the Employee or Dependent was under COBRA and the COBRA coverage is exhausted.

A "Loss of Eligibility" includes a loss of eligibility because of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment or a reduction in the number of hours of employment. A Loss of Eligibility also occurs if the other coverage is provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, if the Employee or Dependent no longer lives or works in the applicable services area (unless the HMO or other arrangement is part of a group plan that makes another benefit option available to the affected Employee or Dependent). In addition, a "Loss of Eligibility" occurs if an individual incurs a claim that would meet or exceed a lifetime limit on all benefits "Exhaustion of COBRA coverage" occurs when COBRA coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or for cause. Exhaustion of COBRA coverage occurs when COBRA coverage ceases because an employer or other responsible party fails to remit premiums on a timely basis. For COBRA coverage provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, exhaustion of COBRA coverage also occurs if coverage ceases because the Employee or Dependent no longer lives or works in the applicable service area (unless other COBRA coverage is available). In addition, exhaustion of COBRA coverage occurs if an individual incurs a claim that would meet or exceed a lifetime limit on all benefits and no other COBRA coverage is available to the individual.

The Plan Administrator may require the Employee to state in writing at the time coverage is offered that other health coverage was the reason for declining enrollment in the Plan (for the Employee or a Dependent). If the Plan Administrator imposes such a requirement and informs the Employee of the requirement, the Employee or Dependent will not be eligible for Special Enrollment based on the loss of coverage unless the Employee provided the required statement at the time coverage was declined.

The Employee or Dependent must request enrollment in the Plan during the Special Enrollment Period, which ends 30 days (1) the other coverage terminates, (2) employer contribution's cease, or (3) COBRA coverage is exhausted, whichever applies. However, if the loss of coverage results

from an individual reaching a lifetime limit on all benefits, the Special Enrollment Period ends 30 days after a claim is denied because of the lifetime limit, except that, if the loss of coverage is exhaustion of COBRA coverage, the Special Enrollment Period ends 30 days after the individual incurs a claim that would exceed the lifetime limit on all benefits. Coverage will be effective no later than the first day of the first month that begins after the Plan Administrator receives a completed request for enrollment..

An individual does not have a Special Enrollment Right if the Employee or Dependent loses other coverage because of a failure to pay premiums or required contributions or if the other coverage is terminated for cause (such as for making a fraudulent claim).

(2) Special Enrollment Rights because of marriage, birth or adoption.

(a) An otherwise eligible Employee (i.e., an Employee who is not a current participant but who has completed any waiting period and any other eligibility requirements under the Plan) may enroll himself or herself in the Plan during the Special Enrollment Period described below if an individual becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption.

(b) A active Participant may enroll an individual who becomes or is his or her spouse (determined under federal law) during the Special Enrollment Period describe below if either (1) the individual becomes the Participant's spouse or (2) the individual is the Participant's spouse and a child becomes a Dependent of the Participant through birth, adoption or placement for adoption.

(c) An otherwise eligible Employee may elect to enroll in the Plan the Employee and an individual who becomes or is his or her spouse (determined under federal law) during the Special Enrollment Period described below if (1) the Employee and the individual become married or (2) the Employee and the individual already are married and a child becomes a Dependent of the Employee through birth, adoption or placement for adoption.

(d) An active Participant may enroll an individual in the Plan during the Special Enrollment Period described below if the individual becomes a Dependent of the Participant through marriage, birth, adoption or placement for adoption.

(e) An otherwise eligible Employee may elect to enroll the Employee and an individual who becomes a Dependent of the Employee (including the Employee's spouse) in the Plan, if the individual becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption.

For purposes of paragraphs (a) through (3) above, "marriage" is limited to marriages that are recognized for purposes of federal law.

The Special Enrollment Period is a period of 30 days that begins on the date of the marriage, birth, adoption or placement for adoption.

Coverage for an Employee or Dependent who enrolls in the Plan because of a marriage, birth or adoption Special Enrollment Right will be effective:

(a) in the case of marriage, no later than the first day of the first month beginning after the date the Plan Administrator receives a completed request for enrollment electing coverage for the Employee or Dependent, if the completed request for enrollment is submitted within 90 days after the marriage;

(b) in the case of a Dependent's birth, on the date of birth if the completed request for enrollment is submitted within 30 days of the birth; or

(c) in the case of a Dependent's adoption or placement for adoption, on the date of the adoption or placement for adoption if the completed request for enrollment is submitted within 30 days of the date of the adoption or placement for adoption.

(3) **Change in Status.** An Employee or Dependent may also enroll in the Plan as a result of an election that is permitted by The Challenge Printing Co., Inc. Section 125 plan, if any, because of a change in status.

If the Employee wishes to move to a higher or lower Plan option, he or she must wait until the next annual re-enrollment period and follow the Plan's provisions for requesting this election change.

(4) **Dependents Residing Outside the United States of America.** If an otherwise eligible Dependent is not enrolled in the Plan because he or she does not reside in the United States, and the Dependent relocates to the United States, the Employee is permitted to enroll the Dependent in the Plan. Coverage will be effective on the date of relocation, provided the request for enrollment in the Plan is received within 30 days after the Dependent relocates to the United States of America. This rule does not apply to coverage provided through a Section 125 plan. For coverage provided through a Section 125 Plan, the Employee will be able to enroll the Dependent under these circumstances only if a Special Enrollment Right applies or a Change in Status election is permitted under the terms of the Section 125 Plan.

ANNUAL ENROLLMENT PERIOD

ANNUAL RE-ENROLLMENT

During the annual re-enrollment period, established by the Plan Sponsor, Covered Employees and their Covered Dependents will be allowed to change some of their benefit decisions reflected on which benefits and coverage are right for them. To the extent previously satisfied, Pre-Existing Conditions Limits will be considered satisfied when changing from one plan option to another plan option.

A Plan Participant who fails to make an election during the annual re-enrollment period will automatically retain his or her present coverage. The contributions required from the Employee will be adjusted automatically for any increases or decreases.

Benefit choices made during the annual re-enrollment period will become effective December 1 and remain in effect until the next December 1 unless the Employee experiences a Special Enrollment Situation or Status Change (refer to Special Enrollment Situation/Status Change subsection).

Plan Participants will receive information regarding the annual re-enrollment period from the Employer.

OPEN ENROLLMENT

During the open enrollment period, established by the Plan Sponsor, eligible Employees and their eligible Dependents who are not currently enrolled in the Plan will be allowed to enroll in the Plan. However, all enrollment applications must be received prior to the open enrollment effective date.

Benefit choices made during the open enrollment period will become effective December 1 and remain in effect until the next December 1 unless the Employee experiences a Special Enrollment Situation or Status Change (refer to Special Enrollment Situation/Status Change subsection).

TERMINATION OF COVERAGE AND EXTENSION OF COVERAGE PROVISIONS

When Employee Coverage Terminates. Employee coverage terminates on the earliest of the following dates:

(1) The date all benefits, or the applicable benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan or by discontinuation of contributions by the Employer.

(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee.

(3) The date the Employee reports to active military service.

(4) The beginning of the period for which a required contribution has not been paid.

Continuation During Periods of Disability, Personal Leave of Absence or Layoff. A covered Employee may remain eligible if Active, full-time work ceases due to a Disability which is certified by a Physician, personal leave of absence or layoff. Continuance of coverage will end as follows:

For Disability leave: The end of the third calendar month that follows the month on which the covered Employee last worked as an Active Employee. Disability leave is concurrent with the Family and Medical Leave (as defined by the Family Medical Leave Act of 1993 (FMLA).

For personal leave of absence: The end of the third calendar month that follows the month in which the covered Employee last worked as an Active Employee.

Layoff: The end of the third calendar month that follows the month on which the covered Employee last worked as an Active Employee.

Continuation of coverage will be coverage which was in force on the last day the covered Employee worked as an Active Employee. However, if benefits reduce for Active Employees in the same Eligible Class, benefits will also reduce for the continued person.

Continuation During Family and Medical Leave (FMLA)

During any leave taken under the Family and Medical Leave Act, the Employer may maintain coverage under the Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the leave period.

If the Employee fails to return to work after the Family and Medical Leave Act, the Employer has the right to recover its contributions toward the cost of coverage during the Family and Medical Leave Act.

If coverage under the Plan terminates during the Family and Medical Leave Act, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work at the end of the Family and Medical Leave Act.

Rehiring a Terminated Employee. Except as otherwise specifically specified in the Plan, a terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all Eligibility, enrollment requirements and Pre-Existing Condition exclusions of the Plan.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights apply only to Employees and their Dependents that were covered under the Plan at the time of leaving for military service.

(1) The maximum period of coverage of an Employee and the Employee's Dependents under such an election shall be the lesser of:

(a) The 24 month period beginning the date on which the Employee's absence begins; or

(b) The period beginning on the day the Employee's military service absence begins and ending on the day after the date on which the Employee returns to employment with the employer or fails to apply for or return to a position of employment with the Employer within the time limit that applies under USERRA.

(2) An Employee who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except an Employee on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) Continuation coverage provided under USERRA counts as COBRA continuation coverage as long as the notice requirements of COBRA are satisfied in connection with the USERRA leave.

(4) An Employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No waiting period or pre-existing condition exclusionary period will apply to an Employee returning from USERRA leave (within the applicable time period) unless the waiting period or exclusionary period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of the following dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to enroll, see the section entitled COBRA Continuation Options):

(1) The date all benefits, or the applicable benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan or by discontinuation of contributions by the Employer.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death.

(3) The date the Dependent reports to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained in the Employees on Military Leave provision of the Plan.

(4) The date a covered Spouse ceases to be a Dependent.

(5) The dependent child ceases to be a Dependent as defined by the Plan.

If the Dependent child loses eligibility under the Plan because he or she reached the limiting age of 19 years and was not a full-time student, and subsequently satisfied the Plan's eligibility requirements of a full-time student, he or she may be reinstated as an eligible Dependent. Coverage will be effective on the first day the student enrolls for the following semester, provided the student enrolls within 30 days of the date he or she registers as a full-time student. The Employer has the right to recover contributions toward the cost of coverage made on behalf of the Employee by the Employer if the Dependent fails to return to school as a full-time student the following semester.

(6) On the last day of the calendar month that a dependent child ceases to be a Dependent as defined by the Plan.

(7) The first day of the period for which the required contribution has not been paid.

PERFORMAX CARE MANAGER PROGRAM

PERFORMAX Care Manager Program Phone Number

PERFORMAX Care Manager
1-800-337-0506

The Covered Person or a family member must call this number to receive certification of certain health care services. This call must be made at least 24 hours in advance of services being rendered or within 48 hours after an admission due to a Medical Emergency.

Penalties for failure to follow PERFORMAX Care Manager procedures will not accrue toward the out-of-pocket maximum.

PERFORMAX CARE MANAGER

PERFORMAX Care Manager is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of Medical Necessity for the following non-emergency services before medical and/or surgical services are provided:

Hospitalizations
Inpatient Substance Abuse/Mental Disorder treatments
Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility stays
Home Health Care
Hospice Care
Outpatient Surgical Procedures, excluding surgery rendered in a Physician's office
Office surgical procedures when requiring general anesthesia
Private duty nursing
IV home infusion therapy
Inpatient Surgical Procedure
Infusion Chemotherapy, including services rendered in a Physician's office

(b) Retrospective review of Medical Necessity of the listed services;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility.

This program is not intended to diagnose or treat medical conditions, guarantee benefits, validate eligibility or to be a substitute for the medical judgment of the attending Physician or other health care provider.

The Covered Person will not be required to obtain precertification from the Plan for a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, the following provisions should be read carefully.

PRECERTIFICATION

Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives the other listed medical services, PERFORMAX Care Manager will, in conjunction with the attending Physician, be required to

certify the care as Medically Necessary. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

PERFORMAX Care Manager program is set in motion by a telephone call from the Covered Person or a family member. PERFORMAX Care Manager must be called, **at least 24 hours before** the listed medical services are scheduled to be rendered, with the following information:

- The name of the Covered Person and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery

If there is a Medical Emergency admission to the Medical Care Facility, the Covered Person, a family member, Medical Care Facility or attending Physician must contact PERFORMAX Care Manager **within 48 hours** of the first business day after the admission.

PERFORMAX Care Manager will determine the number of days of Medical Care Facility confinement or use of other listed medical services that is Medically Necessary. When the required review procedures outlined above are followed, benefits will be unaffected, and the Plan Participant and the Plan avoid expenses related to unnecessary health care.

FAILURE TO FOLLOW REQUIRED REVIEW PROCEDURES

A retrospective review is conducted by the PERFORMAX Care Manager program to determine if the services provided without the Covered Person following the procedures met all other Plan provisions and requirements.

If the review concludes that the services were medically necessary and would have been approved had the required phone call been made, benefits will then be considered as outlined in the Plan. However, any charges not deemed medically necessary will be denied.

The amount the Covered Person pays when PERFORMAX Care Manager review procedures are not followed does not apply to the Plan's out-of-pocket maximum.

CONCURRENT REVIEW, DISCHARGE PLANNING

Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are part of PERFORMAX Care Manager. PERFORMAX Care Manager will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time that was initially precertified, the attending Physician must request the additional services or days.

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

(1) performed on an outpatient basis within seven days of a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) tests performed in an outpatient setting instead of diagnostic tests performed while Hospital confined.

CASE MANAGEMENT

Case Management is a program whereby a case manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. The plan of care may include some or all of the following:

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital, Skilled Nursing Facility, extended care facility or rehabilitation facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

Once agreement has been reached, the Plan will reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient chooses not to participate.

Examples of Illnesses or Injuries that would be appropriate for Case Management include, but are not limited to:

Terminal Illnesses
- Cancer
- AIDS

Chronic Illnesses
- Multiple Sclerosis
- Renal Failure
- Obstructive Pulmonary Disease
- Cardiac Conditions

Accident Victims Requiring Long-Term Rehabilitative Therapy
Newborns with High Risk Complications or Multiple Birth Defects
Diagnosis Involving Long-Term IV Therapy
Illnesses Not Responding to Medical Care
Child and Adolescent Mental Disorders

MATERNITY MANAGEMENT

The primary objective of the Maternity Management program is to anticipate the possibility of a high or moderate risk Pregnancy and help coordinate effective medical care.

It is highly recommended, but not a requirement of the Plan, that an expectant mother call the PERFORMAX Care Manager at 1-800-337-0506 during the first trimester of Pregnancy or upon confirmation of Pregnancy. At this time, an R.N. will ask questions about the expectant mother's general health and medical history. This information will be discussed with the patient's Physician to help determine the risk factor of the Pregnancy.

If the Pregnancy is classified as low risk, the expectant mother may only wish to call again when she is admitted to the Hospital for delivery.

MEDICAL BENEFITS

The following is a description of the medical benefits provided under the Plan. The Plan provides benefits only with respect to covered services and supplies which are Medically Necessary in the specific treatment of a covered Illness or Injury, unless specifically mentioned otherwise in Covered Medical Expenses.

DEDUCTIBLE

Deductible for a Common Accident. This provision applies when two or more Covered Persons in a Family are injured in the same accident.

These Covered Persons will not be required to satisfy separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the calendar year in which the accident occurred will be required as a unit for charges arising from the accident.

BENEFIT PAYMENT

Each calendar year, except as otherwise provided in the Plan, benefits will be paid for covered charges of a Covered Person that are in excess of the deductible and any copayments, but less than the Usual and Customary Amount, if applicable. Payment will be made at the percentages shown as the reimbursement percentage in the Schedule of Benefits.

MAXIMUM BENEFIT AMOUNT

The maximum benefit amount is shown in the Schedule of Medical Benefits. The maximum benefit amount is the total amount of benefits that will be paid under the Plan for all covered charges incurred by a Covered Person.

COVERED MEDICAL EXPENSES

Covered charges are the Usual and Customary Charges, where applicable, incurred for the following services and supplies:

A charge is considered incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care**. Covered medical services and covered supplies furnished by a Hospital or Ambulatory Surgical Center. Covered Hospital charges will be payable as shown in the Schedule of Medical Benefits. This benefit includes Hospital expenses for covered dental services if the attending Physician certifies that care in a Hospital is Medically Necessary to safeguard the health of the patient.

Room and board, including non-routine nursery care, not to exceed the cost of a semiprivate room or other accommodations if the attending Physician certifies Medical Necessity. If a private room is the only accommodation available, the Plan will cover an amount equal to the prevailing semiprivate room rate in that facility.

Charges for an Intensive Care Unit (ICU) and Coronary Care Unit (CCU) stay are payable as described in the Schedule of Medical Benefits and based on the Hospital's ICU or CCU charge.

(2) **Pregnancy Care.** The care and treatment of a Pregnancy is covered the same as any other Illness. This benefit includes services and supplies furnished by a Birthing Center, as shown in the Schedule of Medical Benefits.

(3) **Coverage of Pregnancy.** The care and treatment of Pregnancy is covered the same as any other Illness for a covered Employee or covered Spouse only. This benefit includes services and supplies furnished by a Birthing Center, as shown in the Schedule of Medical Benefits.

The Plan excludes the care and treatment of Pregnancy (including Complications of Pregnancy) for a Dependent daughter.

The Plan generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

(4) **Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility admissions**. The room and board and nursing care furnished by a Skilled Nursing Facility, extended care facility and rehabilitation facility will be payable when approved by PERFORMAX Care Manager, as outlined in the Schedule of Medical Benefits. This benefit does not include treatment related to or for a Mental Disorder or Substance Abuse diagnosis. In order to be eligible, the following must occur:

(a) the Covered Person is confined as a bed patient in the facility;

(b) the attending Physician certifies that confinement is needed for further care of the condition that caused the Hospital confinement; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility, extended care facility or rehabilitation facility.

Covered charges for a Covered Person's care in these facilities are limited to the facility's semiprivate room rate.

(5) **Physician Care.** Inpatient, outpatient, office or home professional services of a Physician for surgical or medical services to treat an Illness or Injury. Inpatient care includes services by an attending Physician or non-attending Physician. This benefit also includes the following:

(a) Treatment of Attention Deficit Disorder (ADD) and/or Attention Deficit Hyperactivity Disorder (ADHD) when treated by a covered Physician with an approved treatment plan.

(b) Initial examination for the diagnosis of a Mental Disorder, including eating disorder (e.g., bulimia, anorexia).

(c) Second surgical opinion (and/or second medical opinion) and necessary third surgical/medical opinions.

(d) Sex counseling/treatment for or related to sexual dysfunction or inadequacies caused by an organic disease or accidental Injury only with an approved treatment plan, for Covered Persons age 18 and over. Drug therapy is covered under the Prescription Drug Program of the Plan.

(e) Physician charges for the administration of birth control injections.

(f) Multiple surgical procedures, subject to the following provisions:

Two (2) or more surgical procedures performed during the same session through the same incision, natural body orifice or operative field. The amount eligible for consideration is the Usual and Customary charge for the largest amount billed for one (1) procedure plus 50% of the sum of Usual and Customary charges for all other procedures performed; or

Two (2) or more surgical procedures performed during the same session through different incisions, natural body orifices or operative fields. The amount eligible for consideration is the Usual and Customary charge for the largest amount billed for one (1) procedure plus 50% of the sum of Usual and Customary charges billed for all other procedures performed.

(g) Assistant Surgeon, if required. The Assistant Surgeon's covered charge will not exceed 25% of the surgeon's Usual and Customary allowance, if applicable.

(6) **Private Duty Nursing Care.** Private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to the following extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit. Inpatient Private Duty Nursing must be pre-certified by PERFORMAX Care Manager and supported by a certification from the attending Physician. Benefits are limited as outlined in the Schedule of Medical Benefits.

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. Charges covered for Outpatient nursing care billed by a Home Health Care Agency are shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care not billed by a Home Health Care Agency must be pre-certified by PERFORMAX Care Manager and supported by a certification and a treatment plan from the attending Physician. Hospice care must be pre-certified by PERFORMAX Care Manager.

(7) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Illness or Injury when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be pre-certified by PERFORMAX Care Manager and supported by a certification and a treatment plan from the attending Physician.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care maximum as outlined in the Schedule of Medical Benefits.

Benefit payment for Home Health Care services is subject to the Home Health Care limit, (up to four (4) hours equal one (1) visit), as outlined on the Schedule of Medical Benefits.

(8) **Hospice Care Services and Supplies.** Covered charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the Covered Person is not expected to live more than six months and has placed the Covered Person under a Hospice Care Plan and only as outlined in the Schedule of Medical Benefits. A Hospice Care Plan primarily provides palliative, supportive, and other related care. Hospice care must be pre-certified by PERFORMAX Care Manager.

Covered bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's covered Spouse and/or covered Dependent Children. Bereavement services must be furnished within six months after the patient's death. Covered charges for Bereavement counseling services are limited as outlined in the Schedule of Medical Benefits.

(9) **Other Medical Services and Supplies.** Services and supplies not otherwise included in the items listed above are covered as follows:

(a) **Acupuncture services,** by a licensed M.D., D.O. or Acupuncturist. Eligible expenses do not include maintenance treatment. Benefits are limited as outlined on the Schedule of Medical Benefits.

(b) **Allergy Services** includes allergy testing, preparation of serum and allergy injections, as outlined in the Schedule of Medical Benefits.

(c) **Ambulance transportation** provided by a professional ambulance service for local land or air transportation for a Medical Emergency. A charge for this service will be considered a covered charge only if the service is to the nearest Hospital or emergency care facility where necessary treatment can be provided.

(d) **Amniocentesis** only when the attending Physician certifies that the procedure is Medically Necessary.

(e) **Anesthetic services** when performed by a licensed anesthesiologist or certified registered nurse anesthetist in connection with a covered surgical procedure.

(f) **Blood** and blood derivatives that are not donated or replaced. Administration of these services is also considered an eligible expense.

(g) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered under the supervision of a Physician and in a Medical Care Facility as defined by the Plan.

(h) **Chemotherapy and radiation treatment** with radioactive substances. The materials and services of technicians are included. Chemotherapy, including services rendered in a Physician's office, must be pre-certified by PERFORMAX Care Manager.

(i) **Contact lenses,** eyeglasses, eye examinations, professional fees for fitting of the lenses, vision therapy and orthoptics are covered only for diagnosis and treatment of an Illness or Injury. Contact lenses or eyeglasses are also covered when needed to replace the human lens lost due to cataract surgery and other intraocular surgeries. Benefits for contact lenses or eyeglasses are limited to the initial prescription only.

(j) **Durable Medical Equipment**, including oxygen and oxygen equipment, if deemed Medically Necessary. A statement is required from the prescribing Physician describing how long the equipment is expected to be Medically Necessary. This statement will determine whether the equipment will be rented or purchased. Benefits are limited to the fair market value of the equipment at the time of purchase. If the equipment is purchased, benefits include expenses related to necessary repairs and maintenance. Initial replacement equipment will be covered if the replacement equipment is required due to a change in the Covered Person's physical condition; or, purchase of new equipment will be less expensive than repair of existing equipment.

(k) **Foot treatment** if deemed Medically Necessary for conditions, including removal of nail roots, surgical procedures or treatment of a metabolic or peripheral vascular disease. Routine foot care such as non-surgical treatment of weak, strained, flat, unstable, or unbalanced feet; metatarsalgia or bunions; corns; callouses; and toe nails is excluded.

(l) **Genetic testing** includes diagnostic testing of genetic information and counseling when medically appropriate. Benefits are limited as outlined in the Schedule of Medical Benefits.

(m) **Hearing examinations**, hearing aids, or related supplies, only when loss of hearing is due to a covered Illness or Injury other than Sensorineural hearing loss.

(n) Care and supplies for diagnostic services rendered for **Infertility** evaluation.

(o) Diagnostic **laboratory studies.**

(p) Treatment of **Mental Disorders and Substance Abuse**. Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment maximums as outlined in the Schedule of Medical Benefits.

Physician's visits are limited to one treatment per day.

Psychiatrists (M.D.), psychologists (Ph.D., Ed-D or Psy.D.), counselors (Ph.D.), Licensed Certified Social Workers (L.C.S.W.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

(q) **Morbid Obesity**, including medical treatment and surgical treatment limited to one per lifetime, will be considered under the Plan when the following criteria is met:

Surgical Treatment:

Presence of morbid obesity must have persisted for at least 5 years, defined as either:

BMI exceeding 40; or BMI greater than 35 in conjunction with ANY of the following severe co-morbidities: Coronary heart disease, type 2 diabetes, clinically significant obstructive sleep apnea or hypertension; AND

The Covered Person has completed growth (18 years of age or documentation of completion of bone growth); AND

Patient has participated in a physician-supervised nutrition and exercise program documented in the medical records. This physician-supervised nutrition and exercise program must meet ALL of the following criteria:

Must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists;

Must be six months or longer in duration;

Must occur within the two years prior to surgery; AND

Must be documented in the medical record by an attending physician who does not perform bariatric surgery.

The following surgery will not be considered as treatment of Morbid Obesity under the Plan:

Loop gastric bypass;

Gastroplasty, more commonly known as "stomach stapling" (not to be confused with vertical band gastroplasty)

Duodenal switch operation;

Biliopancreatic bypass (Scopinaro procedure);

Laparoscopic adjustable silicone gastric banding using the LAP BAND; and

Mini gastric bypass.

(r) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair and related x-rays due to Injury to sound natural teeth. This repair must be made within 12 months from the date of the Injury.

Surgery needed to correct Injuries to the jaw, cheeks, lips, tongue, floor and roof of the mouth.

Surgery needed to correct frenulum or frenum, cleft lip and palate. Benefit includes necessary orthodontic services.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of partially erupted or unerupted teeth.

Charges will not be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, unless otherwise specified, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(s) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician to restore body function lost due to an Injury, Illness or surgery. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy. Benefits are limited as outlined in the Schedule of Medical Benefits.

(t) **Organ transplant** expenses. Benefits are limited as outlined in the Schedule of Medical Benefits.

The maximum benefit for all transplant procedures performed during a Covered Person's Lifetime is included in the Maximum Lifetime Benefit Amount shown in the Schedule of Medical Benefits.

(u) **Organ Donor** expenses. Charges for obtaining donor organs or tissues are covered charges under the Plan for the following:

If a recipient is covered by the Plan – If the organ recipient is covered by the Plan and the organ donor does not have health care coverage for charges to obtain the organ or tissues, the Plan will include these charges under the Lifetime Maximum Benefits under the Plan.

If a recipient is not covered by this Plan – If the recipient is not covered by the Plan, but the donor (our Plan Participant) is a member of the recipients immediate family, the Plan will include these charges under the Lifetime Maximum Benefits under the Plan for donor expenses for obtaining the organ or tissues, but only if the recipient does not have coverage for donor expenses. For the purpose of this plan immediate family member shall include: spouse, child, parent, and sibling.

Donor charges include:

evaluating the organ or tissue;

removing the organ or tissue from the donor; and

transportation of the organ or tissue from within the United States of America and Canada to the place where the transplant is to take place.

(v) **Orthopaedic appliances** that are the original fitting, adjustment and placement of appliances such as braces, casts, splints, crutches, cervical collars, head halters, or other appliances to aid in their function when impaired. Replacement of such devices is only covered if the replacement is necessary due to a change in the physical condition of the Covered Person. This benefit includes expenses for penile implants when necessary due to a covered Illness or Injury.

(w) **Physical therapy** provided by a licensed physical therapist. Therapy must be in accord with a Physician's exact orders as to the type, frequency and duration of therapy and for conditions which are subject to significant improvement through short-term therapy. Eligible expenses do not include maintenance therapy. Benefits are limited as outlined in the Schedule of Medical Benefits.

(x) **Pre-admission and pre-surgical testing** within seven (7) days of a scheduled inpatient Hospital admission, as outlined in the Schedule of Medical Benefits.

(y) Routine **Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as outlined in the Schedule of Medical Benefits.

(z) The initial purchase, fitting and repair of fitted **prosthetic devices**, artificial limbs and artificial eyes, which replace body parts. Replacement of such devices is only covered if the replacement is necessary due to a change in the physical condition of the Covered Person, or, replacement is less expensive than repair of the existing device.

(aa) **Reconstructive Surgery.** Correction of abnormal congenital conditions, birth abnormalities resulting in the malformation or absence of a body part or conditions caused by an accidental Injury or covered Illness. Reconstructive Mammoplasties will also be considered covered charges.

Mammoplasty benefits will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(bb) **Sleep disorder** treatment that is for the diagnosed conditions of sleep apnea, nocturnal seizures and narcolepsy, including biofeedback. Benefits are limited as outlined in the Schedule of Medical Benefits.

(cc) **Smoking cessation.** Includes charges for Prescription Drugs, nicotine gum, non-prescription smoking cessation drugs, supplies, hypnosis, group sessions and withdrawal program. Benefits are limited as outlined in the Schedule of Medical Benefits.

(dd) **Speech therapy** provided by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral

cavity, throat or nasal complex (other than a frenectomy) of a Covered Person; (ii) an Injury; or (iii) an Illness that is other than a learning or Mental Disorder. Benefits are limited as outlined in the Schedule of Medical Benefits.

(ee) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or a D.C. Eligible expenses do not include maintenance treatment. Benefits are limited as outlined on the Schedule of Medical Benefits.

(ff) **Sterilization** procedures.

(gg) **Supplies** such as surgical dressings and other medical supplies, but limited as follows:

(i) Insulin infusion pumps, limited to one (1) in every five (5) years, and related supplies;

(ii) Jobst/compression garments, limited to four (4) per year; and

(hh) **Well Newborn Nursery/Physician Care Charges**.

Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room and board charges and other normal routine care.

This coverage is only provided if the newborn is properly enrolled.

The benefit is limited to charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Physician Care. Benefits are limited to charges incurred by a newborn child while the newborn child is Hospital confined as a result of the child's birth, including circumcision.

(ii) **Wig** or artificial hairpiece expenses and charges associated with the initial purchase of the wig or hairpiece following chemotherapy.

(jj) Diagnostic **X-rays**, including ultrasounds only if the attending Physician certifies that the procedure is Medically Necessary.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs Benefits are shown in the Prescription Drug Program section.

Note: All exclusions related to Dental Benefits are shown in the Dental Plan section.

Note: All exclusions related to Vision Benefits are shown in the Vision Plan section.

For all Medical Benefits shown in the Schedule of Medical Benefits, a charge for the following is not covered:

(1) **Abortion.** Services, supplies, care or treatment in connection with an elective abortion for covered Dependent children. This exclusion does not apply to terminated pregnancies, for the Employee and Spouse only, when the life of the mother is endangered by the continued Pregnancy, in the case of fetal abnormality, or when the Pregnancy is the result of documented rape or incest.

(2) **Administrative costs.** Administrative costs of completing claim forms, itemized bills, medical reports or for providing records, mailing and/or shipping expenses, expenses for broken appointments or expenses for telephone calls.

(3) **Adoption expenses.**

(4) **Artificial Heart or Other Organ.** Artificial heart or other organ and any expenses related to its insertion or maintenance.

(5) **Complications of non-covered surgery or treatment.** Care, services or treatment required as a result of complications from any non-covered surgery or treatment if the complications occur within 12 months of the non-covered surgery or treatment.

(6) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance, Custodial Care or care in a sanitarium.

(7) **Educational or vocational testing.** Services for educational or vocational testing, training, care for learning disorders or behavioral problems whether or not services are rendered in a facility that also provides medical and/or Mental Disorder treatment, except as specified in Covered Medical Benefits.

(8) **Excess charges.** Expenses in excess of the Usual and Customary Charge.

(9) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.

(10) **Experimental and/or Investigational.** Expenses for treatment, procedures, devices, drugs or medicines which are determined to be Experimental and/or Investigational.

(11) **Medically Necessary** - Expenses for goods or services, not Medically Necessary or primarily Cosmetic in nature.

(12) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

(13) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(14) **Government coverage.** Any expenses for care, treatment, supplies or other services or items provided by a government or government-funded program, agency or the like (except as required by applicable law). Any expenses that are eligible for reimbursement by an arrangement of a government or government-funded program or agency (except as required by applicable law) and any expenses that are eligible for reimbursement under a private medical research program.

(15) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy.

(16) **Hazardous Pursuits.** Charges incurred for Injury or Illness relating to a Hazardous Pursuit. This exclusion does not apply to Dependent children up to age 19.

(17) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting unless loss of hearing is due to a covered Injury or Illness.

(18) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and who is paid by the Hospital or facility for the service.

(19) **Illegal act.** Charges incurred for Injury or Illness relating to commission of a felony.

(20) **Infertility.** Care, supplies, services and treatment for infertility, except for diagnostic services rendered for infertility evaluation.

Impregnation procedures, such as but not limited to artificial insemination, in-vitro fertilization, embryo and fetal implantation and G.I.F.T. (gamete intrafallopian transfer) are also excluded.

(21) **Morbid Obesity.** Reversal of any surgical treatment of Morbid Obesity.

(22) **No charge.** Care, treatment and services for which there would not have been a charge if no coverage had been in force.

(23) **Non-emergency Hospital admissions on Friday/Saturday.** Care, treatment and services billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(24) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(25) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; and care, treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Illness.

(26) **Norplant.**

(27) **Not specified as covered.** Non-traditional services, treatments and supplies which are not specified as covered under the Plan, such as, but not limited to holistic, massage therapy, rolfing, hypnosis, homeopathic, biofeedback and naturopathic services.

(28) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Illness. Refer to Medical Benefits and/or Plan Exclusions for Plan provisions regarding care and treatment of Morbid Obesity.

(29) **Occupational.** Any expenses for an Injury or Illness for which the covered Employee or Dependent receives payment under:

Workers' Compensation or a similar law, or
The Occupational Disease Law.

Injury or Sickness for which the covered Employee or Dependent would receive payment under a workers' compensation act or similar law, except for the fact that the person is not covered under a workers' compensation act or similar law. This exclusion only applies to persons that can elect, or could have elected for them, coverage under a workers' compensation act or similar law.

(30) **Orthotics**. Services in connection with orthotics.

(31) **Orthopedic shoes.**

(32) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, television, telephone, guest meals, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, first-aid supplies, non-hospital adjustable beds, heating pads, hot water bottles, waterbeds, hot tubs, swimming pools, or any other equipment that could be used in the absence of an Illness or Injury.

(33) **Plan exclusions.** Charges excluded by the Plan as noted in this document.

(34) **Pregnancy of daughter.** The care and treatment of Pregnancy and Complications of Pregnancy for a Dependent daughter.

(35) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(36) **Removal of breast implants or other prosthetic implants.** Removal of implants are not covered if the implants were: (1) inserted in connection with Cosmetic surgery, regardless of the reason for removal; or (2) not inserted in connection with Cosmetic surgery, but the removal is not Medically Necessary. Includes all expenses for or related to such removal.

(37) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional, or, replacement is less expensive than repair of the existing device.

(38) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Illness or Pregnancy-related condition which is known or reasonably suspected, including routine eye examinations, including refractions, lenses for the eyes and exams for their fitting, unless such care is specifically covered in the Schedule of Medical Benefits.

(39) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under the Plan or after coverage ceased under the Plan.

(40) **Services outside of the United States of America.** Care, treatment or supplies rendered outside the United States of America or its territories, except for covered charges related to an Injury or a Medical Emergency. These services will be considered at the out of network benefit level.

(41) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(42) **Sleep disorders.** Care, treatment, services and supplies for sleep disorders unless for the diagnosed conditions of sleep apnea, nocturnal seizures and narcolepsy.

(43) **Surgical sterilization reversal.** Expenses related to reversal of surgical sterilization.

(44) **Surrogate parenting.** Expenses related to surrogate parenting.

(45) **Temporomandibular Joint Syndrome (TMJ).** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome, unless otherwise stated.

(46) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.

(47) **War, etc.** Any expenses incurred for an Injury or Illness resulting from war declared or undeclared or international armed conflict.

PRESCRIPTION DRUG BENEFITS

Prescription Drug Program

This Prescription Drug Program is an independent program, separate from medical coverage. Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. In order to receive the full benefit of the Prescription Drug Program, a Covered Person must use participating pharmacies and present his or her ID card. PERFORMAX Scrip World is the administrator of the Prescription Drug Program.

Copayments

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the Schedule of Prescription Drug benefits. The copayment amount is not a covered charge under the Medical Benefits and does not apply to the Medical Benefits out-of-pocket. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

Direct Reimbursement

If a drug is purchased from a participating pharmacy when the Covered Person's ID card is not used, the Covered Person must pay the pharmacist the full amount for the prescription. In order for reimbursement to occur, the Covered Person must complete a direct reimbursement form, obtained from the Employer, attach the receipt and submit it to the PERFORMAX Prescription Manager at the following address:

PERFORMAX Scrip World
c/o Express Scripts, Inc.
P.O. Box 66773
St. Louis, MO 63166-6773
Attn.: Claims Department

The Covered Person will be reimbursed the amount that would have been paid to a participating pharmacy, less the applicable copayment.

Mail Order Drug Benefit

The mail order drug benefit is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.).

Covered Prescription Drugs

(1) Prescriptions covered under the Plan include drugs bearing the legend "Caution: Federal law prohibits dispensing without a prescription," except as specified in Prescription Drugs Not Covered. In addition, the following drugs are also covered:

(2) Insulin, glucose monitors, insulin syringes and other diabetic supplies when prescribed by a Physician.

(3) Birth control (e.g., oral contraceptives).

(4) Depo-Provera.

(5) Contraceptive Devices.

Plan Limitations

These limitations apply when a Covered Person incurs an expense for the following covered Prescription Drugs:

(1) Sexual dysfunction, limited to $750 calendar year maximum.

Expenses Not Covered

The Plan will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Drugs used for Cosmetic purposes.** Charges for drugs used for Cosmetic purposes, such as anabolic steroids, or medications for hair growth or removal.

(6) **Experimental/Investigational.** Experimental/Investigational drugs and medicines, even though a charge is made to the Covered Person.

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Fertility drugs.** A charge for fertility medication.

(9) **Growth hormones.** Drugs to enhance physical growth or athletic performance or appearance.

(10) **Immunization.** Immunization agents or biological sera.

(11) **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).

(12) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital or institution confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(13) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(14) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(15) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(16) **No prescription.** Over the counter medications, with the exception of insulin, insulin syringes and insulin-related diagnostic materials.

(17) **Norplant.**

(18) **Refills.** Any refill requested more than one year after the date ordered by the Physician.

(19) **Smoking cessation** or related charges.

VISION BENEFITS

Vision care benefits apply when a Covered Person incurs services for vision care that is recommended and approved by a Physician or Optometrist.

BENEFIT PAYMENT

Benefit payment for a Covered Person will be made as described in the Schedule of Vision Care Benefits.

VISION CARE CHARGES

Vision care charges are the Usual and Customary Charges for the vision care services and supplies shown in the Schedule of Vision Care Benefits. Benefits for these charges are payable up to the maximum benefit amounts shown in the Schedule of Vision Care Benefits for each vision care service or supply. As listed below:

(1) **Vision examinations** by a Physician or Optometrist which include care history, visual acuity (clearness of vision), external examination and measurement; interior examination with ophthalmoscope; pupillary reflexes and eye movements; retinoscopy (shadow test); subjective refraction; coordination measure (far and near); medicating agents for diagnostic purposes; and, analysis of findings with recommendations and prescription if required.

(2) **Glass or plastic lenses** prescribed by a Physician or Optometrist.

(3) **Frames** to hold prescribed lenses.

PLAN LIMITATIONS

The Plan will not provide benefits for any of the items listed below. This list is intended to give a general description of expenses for services and supplies not covered by the Plan. There may be expenses in addition to those listed below which are not covered by the Plan.

(1) **Prior to effective date.** Care, treatment or supplies for which a charge was incurred before a person was covered under the Plan.

(2) **Excluded.** Charges excluded or limited by the Plan design as stated in this document.

(3) **Health plan.** Any charges that are covered under a health plan that reimburses a greater amount than the Plan.

(4) **No prescription.** Charges for lenses ordered without a prescription.

(5) **Orthoptics.** Charges for orthoptics (eye muscle exercises).

(6) **Non-Prescription Sunglasses.** Charges for non-prescription sunglasses, or tints, including Tints # 1 or #2, including prescription type and extra charges for photosensitive or anti-reflective lenses.

(7) **Prescription Sunglasses**.

(8) **Safety goggles**.

(9) **Training.** Charges for vision training or subnormal vision aids.

(10) **Replacement.** Charges for lost, stolen or broken lenses and/or frames, unless within the frequency limitations.

DENTAL BENEFITS

This benefit applies when a Covered Person incurs covered dental charges while covered under the Plan.

DEDUCTIBLE

Individual Deductibles. A deductible is the amount of covered expenses a Covered Person must pay during each calendar year and or Lifetime, if applicable, before the Plan will consider expenses for reimbursement. The individual deductible is shown in the Schedule of Dental Benefits.

Family Deductible Limit. A Family deductible limit is the maximum amount of covered expenses a Family collectively must pay during each calendar year and or Lifetime, if applicable. Once the Family deductible limit is reached, the deductibles of all members of that Family will be considered satisfied for that calendar year. The Family deductible Limit is shown in the Schedule of Dental Benefits.

BENEFIT PAYMENT

Covered dental expenses in excess of the deductible amount will be reimbursed at the percentage shown in the Schedule of Dental Benefits.

MAXIMUM BENEFIT AMOUNT

The maximum dental benefit amount is shown in the Schedule of Dental Benefits.

DENTAL CHARGES

Dental charges are the Usual and Customary Charges (U&C), if applicable, made by a Dentist or Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished, except for the following:

Root-canal therapy is considered incurred on the date the pulp chamber is opened, and

When one overall charge is made for all or part of a course of treatment. In this case, the Claims Processor will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Class A Services:
Preventive and Diagnostic Dental Procedures

The maximums on Class A services are for preventive and diagnostic services.

(1) Routine oral exams. This includes the prophylaxis (cleaning and scaling of teeth). Limit of 2 exam(s) per Covered Person every 12 months.

(2) Bitewing x-ray, limited to two per Covered Person every 12 months.

(3) Full mouth x-ray, limited to once every 36 months.

(4) Panorex, limited to once every 36 months.

(5) Topical application of sodium or stannous fluoride for covered Dependent children under age 19, limited to twice each calendar year.

(6) Space maintainers for covered Dependent children under age 15 to replace primary teeth.

(7) Emergency palliative treatment for pain, limited to once per calendar year.

(8) Harmful Habit appliances, including occlusal night guards, limited to covered Dependents under age 19. Occlusal night guards are limited to one every 36 months.

(9) Other dental x-rays (excluding cephalometric x-rays) necessary for the treatment or diagnosis of localized diseases or abnormalities concerning the teeth and adjacent tissue.

(10) Sealants on the occlusal surface of a permanent posterior tooth for Dependent children under age 15, once per tooth every 12 months.

Class B Services:
Basic Dental Procedures

(1) Consultations.

(2) Study Models.

(3) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.

(4) Treatment of periodontal and other diseases of the gums, limited to one scaling, curettage or surgery per quadrant every six months. Treatment limited to:

Examination of gums and underlying bone
Treatment of gums
Gum surgery to remove infection and reshaping of gums
Bone surgery, including flap entry and closure
Management of acute periodontal infection
Periodontal appliances, only in conjunction with surgery

(5) Perio-prophylaxis, in lieu of any other preventive prophylaxis treatment. Treatment limited to once per quarter.

(6) Occlusal adjustment, only in conjunction with periodontal surgery.

(7) Endodontic Treatment (root canal).

(8) Pulp vitality testing limited to once annually unless specific need exists for emergency diagnosis.

(9) Extractions, simple and erupted. This service includes local anesthesia and routine post-operative care.

(10) Fillings, including amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration for decayed teeth and sedative fillings, excluding gold fillings.

(11) Pin retention in connection with an amalgam or composite restoration.

(12) General anesthetics, or intravenous sedation in connection with oral surgery.

(13) Nitrous oxide, limited to Dependent children under age 12.

(14) Sedative fillings.

(15) Pulp Caps.

Class C Services:
Major Dental Procedures

(1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

(2) Recementing bridges, crowns, inlays or onlays.

(3) Installation of crowns, posts and cores.

(4) Periodontal appliances to stabilize periodontally involved teeth.

(5) Non Cosmetic Veneers.

(6) Installation of full or partial removable dentures to replace one or more natural teeth. This service also includes all adjustments made during the six month period following the installation. This benefit does not include the expenses of installing dentures, which are incurred within the Pre-existing Condition exclusion period if the tooth that is being replaced was lost within the six month period prior to the Covered Person's Enrollment Date under the Plan (refer to the Pre-Existing Conditions subsection of the Eligibility, Funding Effective Date and Termination Provisions section).

(7) Addition or replacement of a broken tooth or clasp to existing partial removable dentures.

(8) Initial installation of fixed bridgework to replace one or more natural teeth. This benefit does not include the expenses of installing bridgework, which is incurred within the Pre-existing Condition exclusion period if the tooth that is being replaced was lost within the six month period prior to the person's Enrollment Date under the Plan (refer to the Pre-Existing Conditions subsection of the Eligibility, Funding Effective Date and Termination Provisions section).

(9) Repair of crowns, bridgework and removable dentures.

(10) Rebasing or relining of removable dentures once in a 24 month period.

(11) Replacing an existing crown, gold filling, removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to

replace newly extracted natural teeth. However, this item will apply only if satisfactory evidence is presented to the Plan that:

(a) The addition of teeth is required because of one or more natural teeth being extracted after the existing denture or bridgework was installed and after the person is covered under the Plan.

(b) The existing dental work, denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.

(c) The existing denture is an immediate temporary denture replacing one or more natural teeth extracted while participation in the Plan, replacement by a permanent denture is required, and the replacement takes place within 12 months from the placement of the temporary denture.

(d) This benefit does not include the addition of teeth if the addition is required because the tooth that is being replaced was lost within the six month period prior to the Covered Person's Enrollment Date and the expense of the replacement is incurred within the Pre-existing Condition exclusion period (refer to the Pre-Existing Conditions subsection of the Eligibility, Funding Effective Date and Termination Provisions section).

Class D Services:
Orthodontic Treatment and Appliances

This benefit is for treatment to move teeth by means of appliances to correct a malocclusion of the mouth.

These services are available for covered Dependent children under age 19 and include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments, adjustment of appliances, cervical traction, and retention appliances but only when one or more of the following conditions is present:

(1) The existence of an extreme bucco-lingual version of the teeth, either unilateral or bilateral. (The teeth are pushed out toward the cheek or in toward the tongue on one or both sides.)

(2) A protrusion of the upper teeth of more than four (4) millimeters.

(3) A protrusive or retrusive relation of the maxillary or mandibular arch of at least one (1) cusp. (The upper and lower teeth buck back.)

(4) An arch length difference of more than four (4) millimeters in either the maxillary or mandibular arch.

(5) A bimaxillary protrusion of four (4) millimeters or more.

(6) A cross-bite.

The Plan will make installment payments for comprehensive full-banded orthodontic treatments.

The Plan will make an initial payment when the first active appliance is placed not to exceed 50% of the Lifetime maximum as outlined on the Schedule of Dental Benefits. The remaining amount will be distributed in equal payments each month during the course of treatment until the earlier of the completion of treatment, the Dependent is no longer covered, maximum benefits have been received or the Plan ends.

If a Covered Person is already in an active course of orthodontic treatment when coverage begins under the Plan, the total benefit amount outlined on the Schedule of Dental Benefits will be calculated and adjusted proportionately based on the following criteria: banding date, length of treatment plan and total charge for treatment.

PREDETERMINATION OF BENEFITS

Prior to dental treatment for which the charge is expected to be $300 or more, a predetermination of benefits is required.

A regular dental claim form is used for the predetermination of benefits. The Dentist should submit a proposed course of treatment prior to the actual performance of services.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Processor at this address:

PERFORMAX Claims Processor
P.O. Box 1065
Amherst, New York 14226
1-877-777-6076

The Claims Processor will evaluate the treatment to determine if it is appropriate for the condition and will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment.

If a predetermination of benefits is not submitted prior to treatment, then the evaluation of the treatment is subject to the Alternate Treatment provision of the Plan and payment will not be guaranteed when the actual services are performed.

ALTERNATE TREATMENT

The Plan has an "alternate treatment" clause which limits the Plan payments to the most cost effective treatment of a dental condition which provides a professionally acceptable result as determined by national standards of dental practice. If a patient chooses a more expensive treatment, to correct a dental condition according to accepted standards of dental practice, the plan payment will be based on the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Customary Charge for an amalgam filling. The patient will pay the difference in cost.

DENTAL PLAN EXCLUSIONS

The Plan will not provide benefits for any of the items listed in this section. There may be expenses in addition to those listed below which are not covered by the Plan:

(1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.

(2) **Athletic mouth guards.**

(3) **Broken appointments.** Charges for broken or missed dental appointments.

(4) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

(5) **Duplicate.** Charges for duplicate prosthetic devices or appliances.

(6) **Endosseous implants.**

(7) **Harmful Habit appliances.** Harmful Habit appliances, except as specified in Covered Dental Services.

(8) **Hospital charges.**

(9) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

(10) **Implants.** Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.

(11) **Medical services.** Services that to any extent, are payable under any medical expense benefits of the Plan.

(12) **Myofunctional therapy.**

(13) **No listing.** Services which are not included in the list of covered dental services.

(14) **Occupational.** Any expenses relating to an Injury or Illnesses that arising out of, incurred in, or connected with the course of any activity for wage or profit, or expenses for which the Covered Person would be entitled to benefits under any worker's compensation, U.S. longshoreman and harbor worker's or other occupational health legislation or policy or any exception or settlement made under the same (whether or not actually in force), or expenses eligible for reimbursement under any other plan, program, insurance coverage, arrangement or the like.

(15) **Orthognathic surgery.** Surgery to correct malpositions in the bones of the jaw.

(16) **Personalization.** Personalization of dentures.

(17) Removal of **partially erupted** or **unerupted** teeth.

(18) **Replacement.** Replacement of lost or stolen appliances.

(19) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are Cosmetic.

(20) **Temporary.** Temporary dental service will be considered an integral part of the final dental service rather than a separate service.

(21) **Veneers.** Veneers are not covered if Cosmetic.

(22) **Tempomandibular Joint Dysfunction (TMJ).** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.

FILING A CLAIM

HOW TO SUBMIT A CLAIM

The following general steps should be followed in order to submit a claim for Medical, Dental, Vision, and Prescription Drugs:

(1) Obtain a claim form from the Human Resource Department, the Plan Administrator or on-line at MyPERFORMAX.com.

(2) Complete the Employee section of the form. Answer all questions, even if the answer is "none" or "N/A" (not applicable), including the section referring to other insurance ("COB"). A separate claim form must be completed for each Covered Person for whom benefits are being requested.

(3) The Physician, Dentist or other provider must complete the provider's portion of the form.

(4) Attach bills for services rendered. Documentation must include:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number and federal tax identification number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of service
- Charges
- If another plan is the primary payor, a copy of the other plan's Explanation of Benefits (EOB) must accompany the claim form sent to the Plan.

(5) Mail the completed claim form and attached documentation to the Claims Processing Office or at the address listed below:

PERFORMAX Claims Processor
P.O. Box 1065
Amherst, New York 14226

Questions regarding the claim can be addressed by calling the following toll-free number:

1-877-777-6076

WHEN CLAIMS MUST BE SUBMITTED

Claims must be filed with the Claims Processor within 365 days of the date the service was incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed after 365 days of the date the service was incurred will be declined.

The Claims Processor will determine if sufficient information has been submitted for appropriate consideration of the claim. If not, additional information may be requested.

CLAIMS PROCEDURE

The Plan's claims procedures are intended to reflect the Department of Labor's claims procedures regulations, and should be interpreted accordingly. In the event of any conflict between the summary and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this summary automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to the claimant.

Initial claims for Plan benefits are made to the Plan Administrator or, if applicable, the Insurer providing that benefit. The Plan Administrator, (or Insurer, if applicable) will review the claim itself or appoint an individual or an entity to review the claim, following these procedures:

(a) Urgent Care Claims. If the claimant's claim is for urgent care health benefits, the reviewer will notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the reviewer will notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the claimant. The claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The reviewer will notify the claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A health benefits claim is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the clalmant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

(b) Concurrent Care Claims. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse benefit determination. In such a case, the reviewer will notify the claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before reduction or termination of the benefit.

Any request by a claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the reviewer will notify the claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

(c) Other Health Benefit Claims. In the case of a health benefit claim not described above:

(i) In the case of a pre-service health benefit claim, the reviewer will notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the

claim by the Plan. If, due to matters beyond the control of the Plan, the reviewer needs additional time to process a claim, the reviewer may extend the time for notifying the claimant of the Plan's benefit determination for up to 15 days, provided that the reviewer notifies the claimant.

(ii) Within 15 days after the Plan receives the claim, of those special circumstances and of when the reviewer expects to make its decision. However, if such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(iii) In the case of a post-service health benefit claim, the reviewer will notify the claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the reviewer needs additional time to process a claim, the reviewer may extend the time for notifying the claimant of the Plan's benefit determination on a one-time basis for up to 15 days, provided that the reviewer notifies the claimant within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment of services which the claimant has already received.

(d) Calculation of Time Periods. For purposes of these time periods relating to the Plan's initial benefit determination, the period of time during which an initial benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to a claimant's failure to submit all information necessary, the period for making the determination is "frozen" from the date the notification is sent to the claimant until the date the claimant responds to the request for additional information.

(e) Manner and Content of Denial of Initial Claims. If the reviewer denies a claim, it must provide to the claimant, in writing or by electronic communication:

(i) The specific reasons for the denial;

(ii) A reference to the Plan provision or insurance contract provision upon which the denial is based;

(iii) A description of any additional information or material that the claimant must provide in order to perfect the claim;

(iv) An explanation of why the additional material or information is necessary;

(v) Notice that the claimant has a right to request a review of the claim denial and information on the steps to be taken if the claimant wishes to request a review of the claim denial along with the time limits applicable to a request for review;

(vi) A statement of the participant's right to bring a civil action under a Federal law called "ERISA" following any denial on review of the initial denial;

(vii) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the claimant and without charge); and

(viii) If the adverse benefit determination is based on the Plan's Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to the claimant's medical circumstances, or (b) a statement that the same will be provided upon request by the claimant and without charge.

NOTE: In the case of an adverse benefit determination concerning a health claim involving urgent care, the information described in this Section may be provided to the claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished to the claimant not later than 3 days after the oral notification.

Reviews of Initially Denied Claims

If a claimant submits a claim for Plan benefits and it is initially denied under the procedures described above, the claimant may request a review of that denial under the following procedures.

(a) Health Benefit Claims. A claimant for health benefits has one hundred eighty (180) days following receipt of a notification of an adverse initial benefit determination within which to request a review of the adverse initial benefit determination. In such cases, the review will meet the following requirements:

(i) The Plan will provide a review that does not afford deference to the adverse initial benefit determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse initial benefit determination that is the subject of the appeal, nor is a subordinate of the individual who made the adverse initial determination.

(ii) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial benefit determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the adverse initial benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

(iii) The Plan will identify to the claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse initial benefit determination, without regard to whether the advice was relied upon in making the adverse initial benefit determination.

(iv) In the case of a requested review of a denied adverse initial benefit determination involving urgent health care, the review process shall meet the expedited deadlines described below. The claimant's request for such an expedited review may be submitted orally or in writing by the claimant and all necessary information, including the Plan's determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.

(v) The reviewer will afford the claimant an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim for benefits and to submit issues and comments relating to the claim for benefits in writing to the Plan Administrator (or Insurer, if applicable). The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim

regardless of whether the information was submitted or considered in the initial benefit determination.

(b) Deadline for Review Decisions.

(i) Urgent Health Benefit Claims. In the case of urgent care health benefit claims, the reviewer will notify the claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of the adverse initial benefit determination by the Plan.

(ii) Other Health Benefit Claims.

a. In the case of a pre-service health claim, the reviewer will notify the claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after receipt by the Plan of the claimant's request for review of the adverse initial benefit determination.

b. In the case of a post-service health claim, the reviewer will notify the claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after receipt by the Plan of the claimant's request for review of the adverse initial benefit determination.

(iii) Calculation of Time Periods. For purposes of the time periods specified in this Section, the period of time during which a benefit determination on review is required to be made begins at the time relating to the Plan's review of adverse initial benefit determination is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a benefit determination or review accompanies the request for review. If a period of time is extended due to a claimant's failure to submit all information necessary, the period for making the determination shall be "frozen" from the date the notification requesting the additional information is sent to the claimant until the date the claimant responds to the request for additional information.

(c) Manner and Content of Notice of Decision on Review. Upon completion of its review of an adverse initial benefit determination, the reviewer will give the claimant, in writing or by electronic notification, a notice containing:

(i) its decision;

(ii) the specific reasons for the decision;

(iii) the relevant Plan provisions or insurance contract provisions on which its decision is based;

(iv) a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the claimant's claim for benefits;

(v) a statement describing the claimant's right to bring an action for judicial review under ERISA Section 502(a);

(vi) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to the claimant upon request;

(vii) if the adverse determination on review is based on a Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the

claimant's medical circumstances, or (b) a statement that such an explanation will be provided without charge upon request; and

(viii) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and, if your benefit is an insured benefit, your State insurance regulatory agency."

Plan's Failure to Follow Procedures

If the Plan fails to follow the claims procedures described above, a claimant will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Insured Benefits and State Insurance Laws

With respect to any insured benefit under the Plan, nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable State law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits is the order of payment when charges are eligible under two or more benefit plans. Coordination of benefits also occurs when the Covered Person is covered by the Plan and Medicare.

When a Covered Person is covered under more than one benefit plan, the "primary" plan will determine and pay benefits first without regard to benefits provided under any other group health plan.

When the Plan is the "secondary" payor, the Plan will coordinate payment with the primary plan in such a way that when the secondary Plan's payment is combined with the primary plan's payment, the total does not exceed the amount the secondary Plan would have paid if it were primary.

For example, if another group health plan is "primary" and the Plan is "secondary," and the "primary" plan pays 70% for a covered benefit while the Plan would pay 80% for the same benefit, the Plan would pay the difference between 70% and 80%, or 10% of the remaining covered expenses. This is called non-duplication of benefits. The balance due, if any, is the responsibility of the Covered Person.

Benefit plan. The Plan will coordinate the medical and dental benefits with the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs, including Medicare.

(5) Other plans required or provided by law. This provision does not include any benefit plan or Medicaid that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance.

Allowable charge. The Plan will consider only covered charges under the Plan as Allowable Charges.

In the case of HMO (Health Maintenance Organization) or other in-network only plans, the Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, the Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of "service type plans" where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

No-Fault limitations. When medical payments are available under vehicle insurance, the Plan will pay excess benefits only, without reimbursement for vehicle plan deductibles. The Plan will always be considered secondary and coordinate with benefits provided or required by any no-fault insurance statute whether or not a no-fault policy is in effect.

Benefit plan payment order. When two or more benefit plans provide benefits for the same Allowable Charge, benefit payment will follow these rules.

(1) Benefit plans that do not have a coordination of benefits provision will pay first.

(2) Benefit plans with a coordination of benefits provision will pay benefits up to the Allowable Charge as follows:

(a) The benefit plan which covers the person directly (that is, as an employee, member or subscriber) will determine benefits thereunder before benefits are considered under a benefit plan which covers the person as a dependent.

(b) The benefit plan which covers a person as an employee who is neither laid-off nor retired will determine benefits before a benefit plan which covers that person as a laid-off or retired employee. The benefit plan which covers a person as a dependent of an employee who is neither laid-off nor retired will determine benefits thereunder before benefits are considered under a benefit plan which covers a person as a dependent of a laid-off or retired employee.

(c) The benefit plan which covers a person as an employee who is neither laid-off nor retired will determine benefits before benefits are considered under a benefit plan which covers that person as a laid-off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(d) The benefit plan which covers a person as an employee who is neither laid-off nor retired or a dependent of an employee who is neither laid-off nor retired will determine benefits before benefits are considered under a benefit plan which covers the person as a COBRA beneficiary.

(e) When a child is covered as a dependent and the parents are not separated or divorced, the following rules will apply:

(i) The benefit plan of the parent whose birthday falls earlier in a year will determine benefits before benefits are considered under a benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefit plan which has covered the patient for the longer period of time will determine benefits before benefits are considered under the benefit plan which covers the other parent.

(f) When a child's parents are divorced or legally separated, the following rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will determine benefits before benefits are considered under the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. First, the benefit plan of the parent with custody determine benefits. Next, the benefit plan of the stepparent that covers the child as a dependent will determine benefits. Finally, the benefit plan of the parent without custody will determine benefits.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will determine benefits before benefits are considered under other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the benefit plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(g) When a child's parents were never married to each other, the rules as set out above in letter (e), will apply as long as paternity has been established.

(h) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer period of time will determine benefits thereunder first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last, as specified in applicable law.

When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare. If the Covered Person did not elect coverage under Medicare Parts A and/or B when eligible, the Plan will be secondary and coordinate with benefits that would have been provided by Medicare.

(4) If a Covered Person is under a disability extension from a previous benefit plan, that benefit plan will pay first and the Plan will pay second.

OTHER IMPORTANT PLAN PROVISIONS

Assignment Of Benefits. No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an Alternate Recipient, in the manner described in ERISA Section 609(a) and in the Plan's QMCSO Procedures.

Inability to Locate Recipient. If the Plan Administrator is unable to make payment to any Covered Person or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Covered Person or other person after reasonable efforts have been made to identify or locate such person (including a notice of the payment so due mailed to the last known address of such Covered Person or other person as shown on the records of the Employer), such payment and all subsequent payments otherwise due to such Covered Person or other person shall be forfeited eighteen (18) months after the date such payment first became due.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. As a condition to receiving benefits under the Plan, Covered Person(s), including all Dependents, agree to transfer to the Plan their rights to make a claim, sue and recover damages when the Injury or Illness giving rise to the benefits occurs through the act or omission of another person.

Alternatively, if a Covered Person receives any full or partial recovery, by way of judgment, settlement or otherwise, from another person or business entity, the Covered Person agrees to reimburse the Plan, in first priority, for any benefits paid by the Plan (i.e., the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by the Plan, from any monies received, with the balance, if any, retained by the Covered Person).

The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment or settlement, etc. specifically designates the recovery, or a portion thereof, as including Plan expenses. Furthermore, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery together with all other previous or anticipated recoveries fully compensates the Covered Person for any damages the Covered Person may have experienced.

This provision is effective regardless of whether an agreement to this effect is actually signed. The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the Covered Person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the Covered Person's own uninsured motorist insurance or underinsured motorist insurance, any medical, disability or other benefit payments, no-fault or school insurance coverage, or other amounts which are paid or payable to or on behalf of the Covered Person.

The Plan may enforce its reimbursement or subrogation rights by requiring the Covered Person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the Covered Person's claim without prior express written authorization by the Plan. The Plan will not be subject to any "make whole" or other subrogation rules.

COBRA CONTINUATION OPTIONS

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan offer covered Employees and their covered spouses and dependent children the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This section is intended to inform you, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in regulations issued by the Department of the Treasury and the Department of Labor. This section is intended to reflect the law and does not grant or take away any rights that apply under applicable law. Instructions on COBRA rights and procedures, as well as election forms and other information, will be provided by the Plan Administrator to Covered Persons who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is group health plan coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at specific rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The continuation coverage is identical to the coverage under the Plan that the Qualified Beneficiary had immediately before the Qualifying Event, or, if the coverage has been changed, the coverage is identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event.

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary is:

(i) Any individual who, on the day before a Qualifying Event, is covered under the Plan as either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee, and who loses coverage under the Plan because of the Qualifying Event.

(ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage.

In addition, if the Qualifying Event is a bankruptcy proceeding under Title 11 of the U.S. Code with respect to an Employer, a covered retired Employee (who retired from employment with that Employer) and any individual who is covered under the Plan as the Spouse, surviving Spouse or Dependent child of such a retired Employee may also be Qualified Beneficiaries. Those individuals are qualified beneficiaries only if (1) for the Employee, he or she retired on or before the date of substantial elimination of coverage and (2) for any other individuals, they were beneficiaries under the Plan on the day before the bankruptcy proceeding commenced.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, for the reason described in the preceding sentence, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual is not a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if an Employee, a Spouse or a Dependent child would lose coverage (i.e., would cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage.

For a covered Employee, the following may be a Qualifying Event:

(i) The termination (other than because of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

For a covered Spouse, in addition to (i), the following may be Qualifying Events:

(ii) The death of a covered Employee.

(iii) The divorce or legal separation of a covered Employee from the Employee's Spouse.

(iv) A covered Employee's entitlement to Medicare.

For a covered Dependent child, in addition to events (i)-(iv) above, the following may be a Qualifying Event:

(v) A Dependent child's ceasing to satisfy the Plan's requirements for coverage as a Dependent child (e.g., attainment of the maximum age for dependency under the Plan).

Finally, for a covered retired Employee (or a Spouse, surviving Spouse, or Dependent who has coverage as the Spouse, surviving Spouse or Dependent of a retired Employee), the following may also be a Qualifying Event:

(vi) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered retired Employee retired at any time.

If the Qualifying Event causes the Employee, or the Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (the persons losing such coverage become Qualified Beneficiaries under COBRA. In addition, if a bankruptcy Qualifying Event causes a former Employee (who retired on or before the date of a substantial elimination of coverage), or such a former Employee's Spouse, surviving Spouse or Dependent child to experience a substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), that former Employee, Spouse, surviving Spouse or Dependent child becomes a Qualified Beneficiary under COBRA. Any increase in contribution that must be paid by a covered Employee, former Employee or the Spouse, surviving Spouse or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if a covered Employee does not return to employment at the end of the FMLA leave. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date. Note that the covered Employee and covered Family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the election period and how long must it last? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. Availability of COBRA continuation coverage is conditioned upon the timely election of such coverage. The election period begins on the date of the Qualifying Event and ends 60 days after the later of (1) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or (2) the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? Yes, in some cases. Each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

(i) A Dependent child's ceasing to be a Dependent child under the Plan.

(ii) The divorce or legal separation of the covered Employee.

A Qualified Beneficiary (or the covered Employee or Spouse) must notify the Plan Administrator within 60 days after the later of the date one of these Qualifying Events occurs.

This notice must be provided, along with any required documentation to:

Plan Administrator
COBRA Qualifying Event
The Challenge Printing Co., Inc.
2 Bridewell Place
Clifton, New Jersey 07014
973-471-4700

The notice must be provided in writing in a letter addressed to the Plan Administrator. The notice must include:

(i) The covered Employee's name, address, phone number and health plan ID number.

(ii) The name, address, phone number and health plan ID number for any Dependent child or Spouse whose eligibility is affected by the qualifying event.

(iii) A description of the Qualifying Event (or a notice of a disability determination or termination of disability status, as described below) and the date on which it occurred.

(iv) The following statement: "By signing this letter, I certify that the Qualifying Event described in this letter occurred on the date described in this letter." If the notice concerns a disability determination or a change in disability status, as described below, this statement is not required.

(v) The signature of the person sending the letter.

The Qualified Beneficiary (or the covered Employee or Spouse) must also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date of the divorce or the date the legal separation began. If a Qualified Beneficiary or anyone else has a question about what type of documentation is required, he or she should contact the Plan Administrator.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse or Dependent child may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of (1) the date of the Qualifying Event or (2) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? COBRA continuation coverage ends on the earliest of the following dates:

(i) The last day of the applicable maximum coverage period.

(ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(iii) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.

(iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other group health plan that does not include an exclusion or limitation with respect to any pre-existing condition that would affect the Qualified Beneficiary.

(v) The date, after the date of the election, that the Qualified Beneficiary is first entitled to Medicare. This date does not apply for anyone who became a Qualified Beneficiary because of a bankruptcy proceeding.

(vi) For a Qualified Beneficiary who is entitled to a disability extension, the later of:

(a) the first day of the first month that is later than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the last day of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA participants, (for example, for fraud.)

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(i) If the Qualifying Event is a termination of employment or reduction of hours of employment, except as provided in paragraphs (ii) and (iii) below, the maximum coverage period ends 18 months after the Qualifying Event.

(ii) If the Qualifying Event is a termination of employment or reduction of hours of employment and the Qualified Beneficiary is entitled to a disability extension, the maximum coverage period ends 29 months after the Qualifying Event if there is a disability extension (unless the disability ends before the end of that 29- month period).

(iii) If a covered Employee becomes entitled to Medicare before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes entitled to Medicare; or

(b) 18 months (or up to 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(iv) For a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is a retired covered Employee (or a surviving Spouse who was participating in the Plan as a surviving Spouse on the day before the bankruptcy Qualifying Event) ends on the date of the covered retired Employee's (or surviving Spouse's) death. The maximum coverage period for a Qualified

Beneficiary who is the Spouse or Dependent child of the covered retired Employee ends 36 months after the death of the covered retired Employee.

(v) For a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(vi) For any Qualifying Event other than those described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the maximum coverage period may be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to last longer than 36 months after the date of the first Qualifying Event.

However, no event is a second Qualifying Event unless that event would have been an initial Qualifying Event if it had occurred for an active covered Employee. For example, an Employee's entitlement to Medicare cannot be a second Qualifying Event for a Spouse or a Dependent child unless an active Employee's entitlement to Medicare would have been an initial Qualifying Event, i.e., unless an Employee's entitlement to Medicare would have resulted in a loss of coverage for the Spouse or Dependent child.

A Qualified Beneficiary (or a covered Employee or Spouse) must notify the Plan Administrator of a second Qualifying Event within 60 days after the later of the date of the Qualifying Event or the date the Qualified Beneficiary would lose coverage because of the Qualifying Event. To submit this notice, the Qualified Beneficiary must follow the procedures described above under **"Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?"**

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary (or a covered Employee or Spouse) must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. To submit this notice, the Qualified Beneficiary must follow the procedures described above under **"Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?"**

If a Qualified Beneficiary becomes entitled to a disability extension and then there is a final determination by the Social Security Administration, under title II or XVI of the Social Security Act, that the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary (or the covered Employee or someone else must notify the Plan Administrator of that determination within 30 days after the date of the final determination. The notice should take the form of a letter as described above under **"Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?"**

Can a Plan require payment for COBRA continuation coverage? Yes. For any period of COBRA continuation coverage, the Plan will require the payment of an amount equal to 102% of the actual cost of coverage except the Plan will require the payment of an amount equal to 150% of the actual cost of coverage for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes.

What is Timely Payment for payment for COBRA continuation coverage? For regular monthly payments, Timely Payment means a payment made by the first day of the month in question (the "due date") or within a 30 day grace period beginning on that due date.

Notwithstanding the above paragraph, the Plan will not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

Special Additional Continuation Coverage Election Period for "TAA-Eligible Individuals". In addition to the other COBRA rules described in the Plan, there are some special rules that apply if an individual is classified as a "TAA-eligible individual" by the U.S. Department of Labor. (This applies only if the individual qualifies for assistance under the Trade Adjustment Assistance Reform Act 2002 because he or she became unemployed as a result of increased imports or the shifting of production to other countries.)

If an individual who is classified by the Department of Labor as a TAA-eligible individual does not elect continuation coverage when he or she first loses coverage, he or she may qualify for an election period that begins on the first day of the month in which the individual becomes a TAA-eligible individual and lasts up to 60 days. However, in no event does this election period last later than 6 months after the date of the individual's TAA-related loss of coverage. If a TAA eligible individual elects continuation coverage during this special election period, continuation coverage would begin at the beginning of that election period, but, for purposes of determining the maximum required COBRA coverage period, the coverage period will be measured from the date of the original Qualifying Event, i.e., the TAA-related loss of coverage.

The Trade Adjustment Assistance Act also provides for a tax credit that may apply to some expenses for continuation coverage. An affected individual should consult with a financial advisor if he or she has questions about the tax credit.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The Plan Sponsor shall be the Plan Administrator. The Plan Administrator shall be the named fiduciary for purposes of ERISA. Except as to those functions reserved to the Plan Sponsor or an Insurer, the Plan administrator shall control and manage the operation and administration of the Plan.

The Plan Administrator shall administer the Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of the Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of interpretation of the Plan and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

SELF-FUNDED NATURE OF PLAN

For Employee and Dependent Coverage: Funding is derived from the funds of the Plan Sponsor and contributions made by the covered Employees.

All Plan benefits are paid from the Employer's general assets. No trust or other separate fund is maintained in connection with the Plan.

The level of any Employee contributions will be set by the Plan Sponsor.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract of employment. Nothing contained in the Plan shall be deemed:

(1) to give any Employee the right to be retained in the employ of the Employer; or

(2) to affect the right of the Employer to discipline or discharge any Employee at any time.

ADMINISTRATIVE ERROR

If, due to an administrative error, an overpayment occurs in a reimbursement amount from the Plan, the Plan retains a contractual right to recover the overpayment. The person or institution receiving the overpayment will be required to return the overpayment. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING, MODIFYING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to covered expenses incurred before termination. If the Plan is amended or modified, expenses incurred prior to the modification or amendment of the Plan will be considered as provided under the terms of the Plan prior to its amendment or modification.

The Employer by action evidenced in writing reserves the right, at any time, without prior notice, to amend, suspend or terminate the Plan in whole or in part. In the event of the dissolution, merger, consolidation or reorganization of the Plan Sponsor, the Plan automatically will terminate unless it is continued by a successor to the Plan Sponsor.

PARTICIPANT'S RIGHTS UNDER ERISA

Plan Participants are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

(1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, and union halls, if applicable, all Plan documents and copies of all documents governing the Plan, including benefit contracts and collective bargaining agreements, if any, and a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including benefit contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and an updated summary plan description. The Employee may have to pay a reasonable charge to the Plan Administrator to cover the cost of photocopying.

(3) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Action By Plan Fiduciaries. In addition to creating rights for Plan Participants, ERISA imposes duties upon the individuals who are responsible for the operation of the employee benefit Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

A Participant May Enforce Rights. If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

Assistance With Questions. If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, or if the Plan Participant needs assistance in obtaining documents from the Plan Administrator, that Plan Participant should contact either the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. The Plan Participant may also obtain certain publications

about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HEALTH INFORMATION PRIVACY

SCOPE OF SECTION

This Section is intended to provide for the Plan's compliance with all applicable requirements of the final Regulations issued by the Department of Health and Human Services pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, including the Regulations entitled Standards for Privacy of Individually Identifiable Health Information (the "Privacy Regulations") and the Regulations entitled Health Insurance Reform: Security Standards (the "Security Standards").

The Plan will comply with all applicable requirements of the Privacy Regulations, as provided in this Section and in the Privacy Regulations and as interpreted pursuant to any subsequent authoritative guidance issued by the Department of Health and Human Services. If there is any conflict between the requirements of the Privacy Regulations and any provision of this Plan, the Privacy Regulations will control. Also, any amendment or revision or authoritative interpretation of the Privacy Regulations is incorporated into the Plan as of the effective date of that guidance.

Notwithstanding the preceding, this Section applies only to those plans that provide health benefits and that are subject to the Privacy Regulations, as determined by the Plan Administrator.

PROTECTED HEALTH INFORMATION

For purposes of this Section, "Protected Health Information" has the same meaning as provided for that term in the Privacy Regulations and is limited to information that is Protected Health Information with respect to the Plan.

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

The Plan will disclose Protected Health Information to the Plan Sponsor only as follows:

(a) Summary Health Information. The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose Protected Health Information that is summary health information to the Plan Sponsor if the Plan Sponsor requests the summary health information for the purpose of:

(i) Obtaining premium bids from insurance issuers for providing health insurance coverage under the Plan; or

(ii) Modifying, amending or terminating the Plan.

For purposes of this subsection, "summary health information" means information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the Plan, from which certain identifying details have been removed, as provided in section 164.504(a) of the Privacy Regulations.

(b) Enrollment Information. The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose to the Plan Sponsor information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health option or HMO offered by the Plan.

(c) Other Disclosures to Plan Sponsor. Except as provided in subsections (a) or (b) above, or under the terms of an applicable individual authorization, the Plan may disclose Protected Health Information to the Plan Sponsor and may permit the disclosure of Protected Health Information by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the Protected Health Information to administer the Plan.

The Plan Sponsor, by signing this document, certifies that it:

(i) will not use or further disclose Protected Health Information other than as permitted or required by the Plan or as required by law;

(ii) will ensure that any agents to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(iii) will not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(iv) will report to the Plan any use or disclosure, of which it becomes aware, of the information that is inconsistent with the uses or disclosures permitted under the Plan;

(v) will make Protected Health Information available to the individual who is the subject of that information in accordance with Section 164.524 of the Privacy Regulations;

(vi) will consider requested amendments to an individual's Protected Health Information in accordance with Section 164.526 of the Privacy Regulations;

(vii) will make available the information required to provide an accounting of disclosures of Protected Health Information in accordance with Section 164.528 of the Privacy Regulations;

(viii) will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Regulations;

(ix) if feasible, will return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form and will retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(x) will ensure that the adequate separation of the Plan and the Plan Sponsor as required in this Section is established.

(d) Prohibited Disclosures. The Plan will not disclose Protected Health Information to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

SEPARATION OF HEALTH PLANS AND PLAN SPONSOR

The Plan is a legal entity separate from the Plan Sponsor. The Plan Sponsor has designated and trained certain employees of the Plan Sponsor as the only employees of the Plan Sponsor who will have access to Protected Health Information. Those employees are identified on the attached Schedule A. If there are any changes to the group of employees who are authorized to have access to Protected Health Information on behalf of the Plan, Schedule A will be updated to reflect those changes. Any revised Schedule A is incorporated into the Plan as of the effective date of the revision without the need for further amendment to the Plan. Employees listed on Schedule A will use or disclose Protected Health Information only to the extent appropriate for performing administrative services that the Plan Sponsor provides for Plan.

The Plan Sponsor will work with the Plan's designated Privacy Official to establish effective policies and procedures for identifying, investigating, remedying and disciplining any alleged instances of noncompliance

with the requirement that employees of the Plan Sponsor who have access to Protected Health Information use that Protected Health Information only for the purposes specified in this Section.

PRIVACY NOTICE

The Plan will comply with the applicable requirements of the Privacy Notice issued by the Plan pursuant to the requirements of the Privacy Regulations and the Plan's Privacy Notice is incorporated into the Plan by this reference. If the Privacy Notice is revised, the Plan will comply with the revised Privacy Notice as of the effective date of the revision. A revised Privacy Notice is incorporated into the Plan as of the effective date of each revision without the need for further amendment of the Plan.

HIPAA SECURITY REGULATIONS

This Subsection is eeffective as of the date the Plan is required to comply with the Security Standards. Beginning on that date, the Plan will comply with all applicable requirements of the Security Standards, as provided in this document and in the Security Standards and as interpreted pursuant to any authoritative guidance issued by the Department of Health and Human Services. If there is any conflict between the requirements of the Security Standards and any provision of this Plan, the Security Standards will control. Also, any amendment or revision or authoritative interpretation of the Security Standards is incorporated into the Plan as of the effective date of that guidance.

In addition, the Plan Sponsor, by adopting this document, certifies that, beginning on the date this Subsection becomes effective, the Plan Sponsor will

Reasonably and appropriately safeguard electronic Protected Health Information created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan;

Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

Ensure that the adequate separation required by Section 164.504(f)(2)(iii) of the Privacy Regulations is supported by reasonable and appropriate security measures;

Ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect that information; and

Report to the Plan any security incident (occurring on or after the date this Subsection becomes effective) of which it becomes aware.

OTHER ADMINISTRATIVE SIMPLIFICATION REGULATIONS

Notwithstanding any other provision of the Plan, the Plan will comply with all applicable requirements of the Administrative Simplification regulations issued by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996, as they become applicable to the Plan and the Plan shall be construed to be consistent with such requirements.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health plan administered by the Employer.

PLAN NAME

The Challenge Printing Company Employee Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 22-1852608

PLAN EFFECTIVE DATE: December 1, 2005

PLAN YEAR: The 12-month period for the Plan Sponsor preceding December 31, unless otherwise stated.

EMPLOYER INFORMATION

The Challenge Printing Co., Inc.
2 Bridewell Place
Clifton, New Jersey 07014
973-471-4700

The Challenge Printing Co. of the Carolinas, Inc.
303 North Main Street
Broadway, North Carolina 27505
973-471-4700

AGENT FOR SERVICE OF LEGAL PROCESS

The Challenge Printing Co., Inc.
2 Bridewell Place
Clifton, New Jersey 07014

CLAIMS PROCESSOR

PERFORMAX Claims Processor
P.O. Box 1065
Amherst, New York 14226
1-877-777-6076